

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12032 CERTIFICATE OF DEATH

Reg. Dist. No. 12013

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Blunche St.</u>		d. STREET ADDRESS <u>25 Blunche St</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Constantia</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-1908</u> yrs. <u>48</u>
9. AGE (In years, less birth day) <u>48</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bd. of Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-36-9609</u>	
17. INFORMANT <u>Walter Adams</u> Address <u>25 Blunche St. Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-16-56</u> , 19 <u> </u> , to <u>12-26-56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12-23-56</u> , 19 <u> </u> , and that death occurred at <u>5:50</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.T. Allen</u> M.D. <u>62</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>12-31-56</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u> ADDRESS <u>Annabopolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Wm French</u> DATE <u>12-31-56</u> 24b. REGISTRAR'S SIGNATURE <u>Wm French</u>	

CERTIFICATE OF DEATH

1956

Name of Deceased <i>James Marshall</i>		Sex <i>Male</i>	
Date of Birth <i>18 June 18</i>		Place of Birth <i>St. Louis, Mo.</i>	
Occupation <i>None</i>		Cause of Death <i>Myocardial Infarction</i>	
Date of Death <i>12 Dec 56</i>		Place of Death <i>Home</i>	
Physician <i>Dr. J. B. Smith</i>		Manner of Death <i>Natural</i>	
Signature of Physician <i>J. B. Smith</i>		Signature of Registrar <i>J. B. Smith</i>	
Date of Entry <i>12 Dec 56</i>		Time of Entry <i>10:00 AM</i>	
Signature of Registrar <i>J. B. Smith</i>		Signature of Deceased <i>James Marshall</i>	

BUREAU V. S.

DEC 31 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12033 CERTIFICATE OF DEATH

Reg. Dist. No.

12014

1. PLACE OF DEATH o. COUNTY <u>Ala.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Ala.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>911 Wells Ave.</u>				d. STREET ADDRESS <u>911 Wells Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William B. Allen</u>				4. DATE OF DEATH <u>12-7-1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EMERY B. ALLEN</u>				14. MOTHER'S MAIDEN NAME <u>BESSE CHRISTIAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mabel Mason Allen</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Esophagitis</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14K</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1/55</u> , 19____, to <u>12-7-56</u> , 19____, that I last saw the deceased alive on <u>12-7-56</u> , 19____, and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. L. W. HART</u>				ADDRESS (Street, city or town, state) <u>ANNAPOLIS MD</u> DATE SIGNED <u>12/8/56</u>			
PHYSICIAN'S NAME (Type) <u>E. L. W. HART</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rogers Family Plot</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
				DATE			

BUREAU V.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12015

12034 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beth Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Convalescent Hosp.</u>		d. STREET ADDRESS <u>5-B. Gilmer Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Anderson</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u></u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>A. A. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Bernice Anderson</u> Address <u>Annapolis</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>1956</u> , to <u>6 Dec</u> , 19 <u>56</u> that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.F. Manuzak</u>		ADDRESS (Street, city or town, state) <u>901 Edgely Rd</u> DATE SIGNED <u>8 Dec 56</u>	
PHYSICIAN'S NAME (Type) <u>H.F. MANUZAK</u>		<u>Helen Durrie, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 9/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Shannon</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>Dec 10 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Wm J. French</u>

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CITY OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		PLACE OF INTERMENT	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF CLERGYMAN		NAME OF CHURCH	
NAME OF HOSPITAL		NAME OF PHYSICIAN	
NAME OF NURSE		NAME OF ASSISTANT	
NAME OF ATTENDING PHYSICIAN		NAME OF ASSISTANT	
NAME OF SECOND PHYSICIAN		NAME OF ASSISTANT	
NAME OF THIRD PHYSICIAN		NAME OF ASSISTANT	
NAME OF FOURTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF FIFTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF SIXTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF SEVENTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF EIGHTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF NINTH PHYSICIAN		NAME OF ASSISTANT	
NAME OF TENTH PHYSICIAN		NAME OF ASSISTANT	

BUREAU V. S.

DEC 11 1956

RECEIVED

12056 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLAN ASHLAND ARMIFER</u>		4. DATE OF DEATH Month Day Year <u>12/20 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 19 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>Friendship Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John ARMIFER</u>		14. MOTHER'S MAIDEN NAME <u>Norfolk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 36025</u>	
17. INFORMANT <u>Ruth ARMIFER</u>		Address <u>Lothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Diabetes Mellitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediately</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>probably arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F D Hendricks</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u>	
DATE SIGNED <u>12-21-56</u>			
PHYSICIAN'S NAME (Type) <u>F D Hendricks</u>		<u>Shady Side, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/22/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>2nd COR</u>	22d. LOCATION (City, town, or county) (State) <u>Lothian Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardesty</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u>12/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12018

12057

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not/given Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Levin Middle Ayres Last Ayres		4. DATE OF DEATH Month 12 Day 27 Year 19 56					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Unk. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Not listed	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min. 56	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Berlin Not/given Md		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown Isaac Ayers				14. MOTHER'S MAIDEN NAME Unknown Minty Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. No		16. SOCIAL SECURITY NO. (If yes, give year or date of service) None Unk.		17. INFORMANT John Ayers, Newark, Address Md. Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility and Malnutrition DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enlargement of prostate, probably carcinoma							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10 , 19 56 , to 12/27 , 19 56 , that I last saw the deceased alive on 12/27 , 19 56 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 12/28/56 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-1-57		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home				24a. REC'D BY REGISTRAR 12/28/56		24b. REGISTRAR'S SIGNATURE J. M. Jones	

CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

File No.

<p>1. NAME OF DECEASED JAMES J. JONES</p>		<p>2. SEX Male</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH 1922</p>	
<p>5. PLACE OF BIRTH New York, N.Y.</p>		<p>6. OCCUPATION Teacher</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1945</p>	
<p>9. NAME OF SPOUSE Mary J. Jones</p>		<p>10. ADDRESS 123 Main St., Boston, Mass.</p>	
<p>11. DATE OF DEATH 1957</p>		<p>12. PLACE OF DEATH Home</p>	
<p>13. CAUSE OF DEATH Heart Disease</p>		<p>14. MANNER OF DEATH Natural</p>	
<p>15. SIGNATURE OF PHYSICIAN Dr. J. A. Smith</p>		<p>16. SIGNATURE OF REGISTRAR John Doe</p>	

BUREAU V. 2

RECEIVED

AN 2 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

12035

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 REVELL ST.</u>		d. STREET ADDRESS <u>12 REVELL ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERIKA</u> <u>BAEUMKER</u>		4. DATE OF DEATH Month Day Year <u>DEC.</u> <u>28</u> <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1, 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> <u>LANSBARGE ON THE WARTHE</u>
12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u> ✓		13. FATHER'S NAME <u>FRANZ BEHREND</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA REISSER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ADOLPH E. BAEUMKER #1 (HUSBAND)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chondrosarcoma of left lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases in mediastinum</u> c. <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>June 56</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>56</u> , to <u>12-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-28-56</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D. <u>45 Franklin St. Annapolis, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D. 45 FRANKLIN ST. ANNAPOLIS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-31-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD.</u>		24a. REC'D BY REGISTRAR <u>12/31/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. J. - U. Munch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 2 1957
BUREAU V.

242

PTREAU

12058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3mo. 28 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Last Name</u> <u>BARNES</u>		Middle <u>GEORGE</u>		Last <u>W.</u>		4. DATE OF DEATH Month <u>12-21</u> Day <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Grooms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT <u>Hospital Record</u> Address <u>Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and Congestive Heart Failure</u> DUE TO (b) <u>Aortitis - Luetic</u> DUE TO (c) <u>Cardiac Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-24-56</u> , 19 <u>56</u> to <u>12-21-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-21-56</u> , 19 <u>56</u> , and that death occurred at <u>11:00a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>Crownsville, Md.</u>				DATE SIGNED <u>12-21-56</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>12/26/1956</u>		<u>Baltimore Cemetery</u>		<u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katy Williams</u>				ADDRESS <u>Schroeder St.</u>		24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. M. M. Jones</u>			

BUREAU V. S.

DEC 28 1956

RECEIVED

12059

CERTIFICATE OF DEATH

12021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. LENGTH OF STAY IN 1b <u>Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Taney Rd.</u>		d. STREET ADDRESS <u>505 Taney Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Barnhart</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension & Cardiac</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular disease.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/3</u> , 19 <u>54</u> , to <u>Dec. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 15</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dec. 15, 56</u> DATE SIGNED ACTUAL SIGNATURE <u>Philip W. Keister</u> M.D. <u>302 Patapsco Ave.</u> PHYSICIAN'S NAME (Type) <u>G. R. Yuan</u> <u>Brooklyn, Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Husbands Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Somerset, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		24a. REC'D BY REGISTRAR DATE <u>17 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Jo. Whitcomb</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JAMES		2. SEX MALE	
3. AGE 30		4. DATE OF BIRTH 1926	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1945	
9. NAME OF SPOUSE MARY J. JAMES		10. DATE OF DEATH 1956	
11. PLACE OF DEATH HOME		12. CAUSE OF DEATH HEART DISEASE	
13. MEDICAL HISTORY NO		14. ALCOHOLIC HISTORY NO	
15. TOBACCO HISTORY NO		16. DRUG HISTORY NO	
17. OTHER HISTORY NO		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. DATE OF REGISTRATION 1956	

BUREAU V. 1

DEC 17 1956

RECEIVED

12036 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>				d. STREET ADDRESS <u>614 - 3rd Street</u>			
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Columbus</u> Middle <u>Blunt</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1922</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>East Port, Md</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Charles Blunt</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Ellen Hall</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>220-21-6369</u>				17. INFORMANT Address <u>Elizabeth Blunt - 614 3rd St. Annapolis, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive lobular disease, IV</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/11</u> , 19 <u>56</u> , to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson Jr</u>				ADDRESS (Street, city or town, state) <u>37 E. Street Street</u>			
PHYSICIAN'S NAME (Type) <u>Dr THEODORE H. JOHNSON</u>				DATE SIGNED <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-18-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md</u>				ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>26 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Don J. Louch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. NO.

Name of Deceased		Age	
Charles Robert		11-1-1922	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Place of Birth		Baltimore, Md.	
Date of Death		Dec 26 1956	
Time of Death		10:15 AM	
Cause of Death		Sudden	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

DEC 26 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12024

CERTIFICATE OF DEATH

12060

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Tracy</i>		LENGTH OF STAY (In this place) <i>12 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Tracy Md.</i>		TOWN <i>Tracy Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Eldridge Bowen</i>				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>2</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 2, 1886</i>	9. AGE last birthday <i>70</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Stanley Bowen</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Hall</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr Charles Bowen Tracy Md</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Old 2.B.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Old 2.B.</i>				<i>2 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Has been at Sanatorium</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/24</i> , 19 <i>58</i> , to <i>12/2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>12/1</i> , 19 <i>56</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>H W Ward</i>				ADDRESS (Street, city, town, state) <i>Owings Md</i>		DATE SIGNED <i>12/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/4/56</i>		NAME OF CEMETERY OR CREMATORY <i>Friendship</i>		LOCATION (City, town, or county) (State) <i>Friendship Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Steve L. Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm H. Williams</i>		ADDRESS	
DATE <i>12/3/56</i>							

CERTIFICATE OF DEATH

Form 1-1-55

1. NAME OF DECEASED

MARYLAND

COUNTY OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO DRESSING ROOM

DATE OF ENTRY INTO BATHROOM

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

DATE OF ENTRY INTO BALCONY

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO TERRACE

DATE OF ENTRY INTO BALCONY

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

BUREAU V. 3

DEC 17 1956

RECEIVED

DISCONTINUED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12037 CERTIFICATE OF DEATH

12025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md USNH</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>82 Conduit Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S.Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>(n)</u> Last <u>BRANSON</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-07</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Francis Devlin</u>		14. MOTHER'S MAIDEN NAME <u>Johanna (n) Daley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>U.S.Naval Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition, severe</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma, colon with Metastasis, multiple</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>10-29</u> , 19 <u>56</u> , to <u>12-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-25-56</u> , 19 <u>56</u> , and that death occurred at <u>3:10 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Robert A Sherry</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert A SHERRY</u> LT. MC USNR U.S.Naval Hospital, Anna. Md. <u>12-26-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR DATE <u>12-27-56</u>	
ADDRESS <u>Son Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12061 CERTIFICATE OF DEATH

13101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNA ARUNDEL, JESSUPS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jessups, Md.				c. LENGTH OF STAY IN 1b 17 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland House of Correction				e. STREET ADDRESS 457 W. South Street			
4. DATE OF DEATH Month December Day 17 Year 1956				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Monroe Last Bruchey				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH March 9, 1906 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) UNKNOWN				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME David Bruchey				14. MOTHER'S MAIDEN NAME Elizabeth Hann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Nephrosclerosis with 446X DUE TO generalized edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month 19 Day Year				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 8 , 1955, to December 17 , 1956, that I last saw the deceased alive on December 17 , 1956, and that death occurred at 7:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B Taylor				ADDRESS (Street, city or town, state) Maryland House of Correction Jessup Md			
PHYSICIAN'S NAME (Type)				DATE SIGNED 12-18-56			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		20 Dec 1956		Mount Olivet Cemetery		Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Stachurski				ADDRESS Frederick Md		24a. REC'D BY REGISTRAR DATE 1/10/57	
				24b. REGISTRAR'S SIGNATURE Clare Hadley			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Robert A. Taylor</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 10 1955</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Methodist</i>	
13. MARITAL STATUS <i>Married</i>		14. DATE OF MARRIAGE <i>1930</i>		15. NAME OF SPOUSE <i>Elizabeth Taylor</i>	
16. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		17. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		18. NAME OF NURSE <i>Miss Jones</i>	
19. NAME OF CORONER <i>John Doe</i>		20. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		21. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
22. NAME OF FUNERAL HOME <i>Funeral Home</i>		23. NAME OF CEMETERY <i>Greenwood Cemetery</i>		24. NAME OF INTERMENT <i>Interment</i>	
25. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		26. NAME OF MINISTER <i>Rev. Mr. Brown</i>		27. NAME OF FUNERAL HOME <i>Funeral Home</i>	
28. NAME OF CEMETERY <i>Greenwood Cemetery</i>		29. NAME OF INTERMENT <i>Interment</i>		30. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	
31. NAME OF MINISTER <i>Rev. Mr. Brown</i>		32. NAME OF FUNERAL HOME <i>Funeral Home</i>		33. NAME OF CEMETERY <i>Greenwood Cemetery</i>	
34. NAME OF INTERMENT <i>Interment</i>		35. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		36. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
37. NAME OF FUNERAL HOME <i>Funeral Home</i>		38. NAME OF CEMETERY <i>Greenwood Cemetery</i>		39. NAME OF INTERMENT <i>Interment</i>	
40. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		41. NAME OF MINISTER <i>Rev. Mr. Brown</i>		42. NAME OF FUNERAL HOME <i>Funeral Home</i>	
43. NAME OF CEMETERY <i>Greenwood Cemetery</i>		44. NAME OF INTERMENT <i>Interment</i>		45. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	
46. NAME OF MINISTER <i>Rev. Mr. Brown</i>		47. NAME OF FUNERAL HOME <i>Funeral Home</i>		48. NAME OF CEMETERY <i>Greenwood Cemetery</i>	
49. NAME OF INTERMENT <i>Interment</i>		50. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		51. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
52. NAME OF FUNERAL HOME <i>Funeral Home</i>		53. NAME OF CEMETERY <i>Greenwood Cemetery</i>		54. NAME OF INTERMENT <i>Interment</i>	
55. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		56. NAME OF MINISTER <i>Rev. Mr. Brown</i>		57. NAME OF FUNERAL HOME <i>Funeral Home</i>	
58. NAME OF CEMETERY <i>Greenwood Cemetery</i>		59. NAME OF INTERMENT <i>Interment</i>		60. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	
61. NAME OF MINISTER <i>Rev. Mr. Brown</i>		62. NAME OF FUNERAL HOME <i>Funeral Home</i>		63. NAME OF CEMETERY <i>Greenwood Cemetery</i>	
64. NAME OF INTERMENT <i>Interment</i>		65. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		66. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
67. NAME OF FUNERAL HOME <i>Funeral Home</i>		68. NAME OF CEMETERY <i>Greenwood Cemetery</i>		69. NAME OF INTERMENT <i>Interment</i>	
70. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		71. NAME OF MINISTER <i>Rev. Mr. Brown</i>		72. NAME OF FUNERAL HOME <i>Funeral Home</i>	
73. NAME OF CEMETERY <i>Greenwood Cemetery</i>		74. NAME OF INTERMENT <i>Interment</i>		75. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	
76. NAME OF MINISTER <i>Rev. Mr. Brown</i>		77. NAME OF FUNERAL HOME <i>Funeral Home</i>		78. NAME OF CEMETERY <i>Greenwood Cemetery</i>	
79. NAME OF INTERMENT <i>Interment</i>		80. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		81. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
82. NAME OF FUNERAL HOME <i>Funeral Home</i>		83. NAME OF CEMETERY <i>Greenwood Cemetery</i>		84. NAME OF INTERMENT <i>Interment</i>	
85. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		86. NAME OF MINISTER <i>Rev. Mr. Brown</i>		87. NAME OF FUNERAL HOME <i>Funeral Home</i>	
88. NAME OF CEMETERY <i>Greenwood Cemetery</i>		89. NAME OF INTERMENT <i>Interment</i>		90. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	
91. NAME OF MINISTER <i>Rev. Mr. Brown</i>		92. NAME OF FUNERAL HOME <i>Funeral Home</i>		93. NAME OF CEMETERY <i>Greenwood Cemetery</i>	
94. NAME OF INTERMENT <i>Interment</i>		95. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		96. NAME OF MINISTER <i>Rev. Mr. Brown</i>	
97. NAME OF FUNERAL HOME <i>Funeral Home</i>		98. NAME OF CEMETERY <i>Greenwood Cemetery</i>		99. NAME OF INTERMENT <i>Interment</i>	
100. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		101. NAME OF MINISTER <i>Rev. Mr. Brown</i>		102. NAME OF FUNERAL HOME <i>Funeral Home</i>	

Robert A. Taylor
Engineer

BUREAU V. S.

JAN 10 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Thompson Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Thompson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis John Buddenbohn</u>		4. DATE OF DEATH <u>Dec. 22, 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1915</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Plastics</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Buddenbohn</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-18-0889</u>	
17. INFORMANT <u>Mrs Louise Buddenbohn, same as 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Self inflicted Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>974X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased tied a rope around his neck and fastened it to a rafter</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:30 am 12/22/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Severn, AA Co. Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/22/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) <u>Glen Burnie, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASES PRESENT	
SIGNATURE OF EXAMINER		DATE		TIME	

RECEIVED
DEC 26 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12027

12063 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. LENGTH OF STAY IN 1b <u>14 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW ROAD</u>				d. STREET ADDRESS <u>MEADOW RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LOUIS CHAMBERS</u>				4. DATE OF DEATH Month Day Year <u>DEC. 2 19 56</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 31, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROLLER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TIN MILL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Family - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>30 MONTHS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>54</u> , to <u>DEC. 2</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>NOV. 29</u> , 19 <u>56</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u> DATE SIGNED <u>12/2/56</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY Smith</u>				ADDRESS <u>RIVIERA BEACH MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALLO</u>		22d. LOCATION (City, town, or county) (State) <u>BALLO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary Shumel</u> ADDRESS <u>Hawes</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Seaberg</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1956

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. DATE OF BIRTH [Faint text]</p>		<p>4. PLACE OF BIRTH [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>16. SIGNATURE OF CEMETERY [Faint text]</p>	
<p>17. SIGNATURE OF CHURCH [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	
<p>19. SIGNATURE OF OTHER [Faint text]</p>		<p>20. SIGNATURE OF OTHER [Faint text]</p>	
<p>21. SIGNATURE OF OTHER [Faint text]</p>		<p>22. SIGNATURE OF OTHER [Faint text]</p>	
<p>23. SIGNATURE OF OTHER [Faint text]</p>		<p>24. SIGNATURE OF OTHER [Faint text]</p>	
<p>25. SIGNATURE OF OTHER [Faint text]</p>		<p>26. SIGNATURE OF OTHER [Faint text]</p>	
<p>27. SIGNATURE OF OTHER [Faint text]</p>		<p>28. SIGNATURE OF OTHER [Faint text]</p>	
<p>29. SIGNATURE OF OTHER [Faint text]</p>		<p>30. SIGNATURE OF OTHER [Faint text]</p>	
<p>31. SIGNATURE OF OTHER [Faint text]</p>		<p>32. SIGNATURE OF OTHER [Faint text]</p>	
<p>33. SIGNATURE OF OTHER [Faint text]</p>		<p>34. SIGNATURE OF OTHER [Faint text]</p>	
<p>35. SIGNATURE OF OTHER [Faint text]</p>		<p>36. SIGNATURE OF OTHER [Faint text]</p>	
<p>37. SIGNATURE OF OTHER [Faint text]</p>		<p>38. SIGNATURE OF OTHER [Faint text]</p>	
<p>39. SIGNATURE OF OTHER [Faint text]</p>		<p>40. SIGNATURE OF OTHER [Faint text]</p>	
<p>41. SIGNATURE OF OTHER [Faint text]</p>		<p>42. SIGNATURE OF OTHER [Faint text]</p>	
<p>43. SIGNATURE OF OTHER [Faint text]</p>		<p>44. SIGNATURE OF OTHER [Faint text]</p>	
<p>45. SIGNATURE OF OTHER [Faint text]</p>		<p>46. SIGNATURE OF OTHER [Faint text]</p>	
<p>47. SIGNATURE OF OTHER [Faint text]</p>		<p>48. SIGNATURE OF OTHER [Faint text]</p>	
<p>49. SIGNATURE OF OTHER [Faint text]</p>		<p>50. SIGNATURE OF OTHER [Faint text]</p>	
<p>51. SIGNATURE OF OTHER [Faint text]</p>		<p>52. SIGNATURE OF OTHER [Faint text]</p>	
<p>53. SIGNATURE OF OTHER [Faint text]</p>		<p>54. SIGNATURE OF OTHER [Faint text]</p>	
<p>55. SIGNATURE OF OTHER [Faint text]</p>		<p>56. SIGNATURE OF OTHER [Faint text]</p>	
<p>57. SIGNATURE OF OTHER [Faint text]</p>		<p>58. SIGNATURE OF OTHER [Faint text]</p>	
<p>59. SIGNATURE OF OTHER [Faint text]</p>		<p>60. SIGNATURE OF OTHER [Faint text]</p>	
<p>61. SIGNATURE OF OTHER [Faint text]</p>		<p>62. SIGNATURE OF OTHER [Faint text]</p>	
<p>63. SIGNATURE OF OTHER [Faint text]</p>		<p>64. SIGNATURE OF OTHER [Faint text]</p>	
<p>65. SIGNATURE OF OTHER [Faint text]</p>		<p>66. SIGNATURE OF OTHER [Faint text]</p>	
<p>67. SIGNATURE OF OTHER [Faint text]</p>		<p>68. SIGNATURE OF OTHER [Faint text]</p>	
<p>69. SIGNATURE OF OTHER [Faint text]</p>		<p>70. SIGNATURE OF OTHER [Faint text]</p>	
<p>71. SIGNATURE OF OTHER [Faint text]</p>		<p>72. SIGNATURE OF OTHER [Faint text]</p>	
<p>73. SIGNATURE OF OTHER [Faint text]</p>		<p>74. SIGNATURE OF OTHER [Faint text]</p>	
<p>75. SIGNATURE OF OTHER [Faint text]</p>		<p>76. SIGNATURE OF OTHER [Faint text]</p>	
<p>77. SIGNATURE OF OTHER [Faint text]</p>		<p>78. SIGNATURE OF OTHER [Faint text]</p>	
<p>79. SIGNATURE OF OTHER [Faint text]</p>		<p>80. SIGNATURE OF OTHER [Faint text]</p>	
<p>81. SIGNATURE OF OTHER [Faint text]</p>		<p>82. SIGNATURE OF OTHER [Faint text]</p>	
<p>83. SIGNATURE OF OTHER [Faint text]</p>		<p>84. SIGNATURE OF OTHER [Faint text]</p>	
<p>85. SIGNATURE OF OTHER [Faint text]</p>		<p>86. SIGNATURE OF OTHER [Faint text]</p>	
<p>87. SIGNATURE OF OTHER [Faint text]</p>		<p>88. SIGNATURE OF OTHER [Faint text]</p>	
<p>89. SIGNATURE OF OTHER [Faint text]</p>		<p>90. SIGNATURE OF OTHER [Faint text]</p>	
<p>91. SIGNATURE OF OTHER [Faint text]</p>		<p>92. SIGNATURE OF OTHER [Faint text]</p>	
<p>93. SIGNATURE OF OTHER [Faint text]</p>		<p>94. SIGNATURE OF OTHER [Faint text]</p>	
<p>95. SIGNATURE OF OTHER [Faint text]</p>		<p>96. SIGNATURE OF OTHER [Faint text]</p>	
<p>97. SIGNATURE OF OTHER [Faint text]</p>		<p>98. SIGNATURE OF OTHER [Faint text]</p>	
<p>99. SIGNATURE OF OTHER [Faint text]</p>		<p>100. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. 3

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12038

CERTIFICATE OF DEATH

12028

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>		c. LENGTH OF STAY IN 1b <u>4 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ann Arundel Gen. Hospital</u>		d. STREET ADDRESS <u>RFD #1</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>COSAND</u> Middle <u>LAST</u> Last		4. DATE OF DEATH <u>December 4, 1956</u> Month <u>December</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR <u>X</u> UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crownsville St. Hosp.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON STATE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>578-10-7919</u>	
17. INFORMANT <u>Mrs. Bertha McCasand</u> Address <u>Pt. 1 Severna, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331x</u> DUE TO (c) <u>331x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1</u> , 1956, to <u>12/4</u> , 1956, that I last saw the deceased alive on <u>12/6</u> , 1956, and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate W. Annapolis</u> DATE SIGNED <u>12/4/56</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec-7, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Gambrells Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 6 1956</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1. DATE OF DEATH		2. PLACE OF DEATH	
3. TIME OF DEATH		4. NAME OF DECEASED	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF CEMETERY OFFICIAL	
21. SIGNATURE OF HEALTH DEPARTMENT		22. SIGNATURE OF COUNTY CLERK	
23. SIGNATURE OF STATE CLERK		24. SIGNATURE OF U.S. DEPARTMENT OF HEALTH	

RECEIVED
DEC 6 1956
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12029

12064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 117 ROUTE 2 HAMMERSLEE BEACH</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUSTIN LITZINGER COULBOURN</u>				4. DATE OF DEATH Month Day Year <u>DEC. 22 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19, 1917</u>	9. AGE (In years last birthday) yrs. <u>39</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTOMOTIVE EQUIP.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOTIVE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>SEWARD L. COULBOURNE</u>				14. MOTHER'S MAIDEN NAME <u>LUDIE TGLE HART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. ANNA COULBOURNE</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma glands (Cervical)</u> <u>198X</u> DUE TO <u>Metastases to lungs & liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 m.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 19</u> , 19 <u>56</u> , to <u>Dec 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>56</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>				M.D. <u>L. L. Lintner</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES L. BALL JR.</u>				ADDRESS (Street, city or town, state) <u>LINTNER, AAC, MD</u>			
DATE SIGNED <u>12/22/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL Cem</u>		22d. LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL Co., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Bone</u>				ADDRESS <u>4501 Ritchie</u>		24a. REC'D BY REGISTRAR <u>DATE 28 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Lintner</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12030

Reg. Dist. No.

<p style="font-size: 1.5em; margin: 0;">12065</p>				<p style="font-size: 1.5em; margin: 0;">24</p>			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clark Station</u>				d. STREET ADDRESS <u>Clark Station</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Edward</u> Last <u>Cummings</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>19,</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/22/91</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Cummings</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>1911 - 1932</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Naval Discharge Papers</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u>				24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 28 1956
BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12031

12066

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNIE ARUNDEL</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>FERNDALE</u>		LENGTH OF STAY (In this place)		TOWN <u>Ferndale (Glen Burnie P.O.)</u>		TOWN <u>Ferndale (Glen Burnie P.O.)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 FERNDALE Road.</u>				STREET ADDRESS <u>8 Ferndale Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>DA</u> (Last) <u>VAULT</u>				(Month) <u>DECEMBER</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 24, 1922</u>	9. AGE last birthday <u>34</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Watts</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Trazarre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Edwin A. Davault Ferndale, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332x IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>none</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2</u> , 19 <u>56</u> , to <u>12/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>56</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bobby L. Jones</u>				ADDRESS (Street, city, town, state) <u>M.D. 104 Crane Hwy & Glen Burnie Md.</u>		DATE SIGNED <u>12/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 6 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Sedberry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

Usual Residence - Hospital Declassed

Place of Death

Age

Sex

Color

Marital Status

Occupation

Cause of Death

Medical History

Medical Examination

Signature of Physician

Date

Signature of Registrar

Date

Signature of Coroner

Date

Signature of Burial Officer

Date

BUREAU V. 8

DEC 6 1966

RECEIVED

SHORT-TERM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12032

12067 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b 3½ months		d. STREET ADDRESS 2401 Louretta Av.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle Finny Last Deer		4. DATE OF DEATH Month 12 Day 2 Year 1956	
5. SEX F	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1906
9. AGE (In years) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Katie Finny	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Crownsville State Hospital, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 3½ mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15/56 , 19____, to 12/2/56 , 19____, that I last saw the deceased alive on 12/2/56 , 19____, and that death occurred at 3.30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED ACTUAL SIGNATURE Ludwig Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D. Crownsville, Md. 12/2/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/5/56		22b. DATE THEREOF 12/5/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. M. Nelson		24a. REC'D BY REGISTRAR DATE 12/4/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE K. M. Joyce	

CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
Date of death		Place of death		Cause of death	
Occupation		Usual residence		Manner of death	
Signature of physician		Signature of registrar		Signature of informant	
Date of registration		Place of registration		County	
State		City		Zip	

BUREAU V. S.

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12033

CERTIFICATE OF DEATH

12039

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Annapolis</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Woodbine</i>		06x2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Convalescing Home</i>				STREET ADDRESS (If rural give location) --			
3. NAME OF DECEASED (Type or Print) <i>ADELE E. DENSMORE</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>DEC. 9 1956</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>8/17/1870</i>	9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Minneapolis, Minn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William G. Kempton</i>				14. MOTHER'S MAIDEN NAME <i>Jeanette Rosette Fox</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Ruth D. McNally- Rt. 2- Woodbine P.O.-Maryland</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <i>Arteriosclerotic Coronal Arterial Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>yes 3 wks.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9me 12</i> , 19 <i>56</i> , to <i>dec 9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>dec 7</i> , 19 <i>56</i> , and that death occurred at <i>7:57 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Mamie Klawans</i>				DATE SIGNED <i>31 South 5th St. Annapolis, Md 12/9/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>12/11/56</i>		NAME OF CEMETERY OR CREMATORY <i>Lakewood Cemetery</i>		LOCATION (City, town, or county) (State) <i>Minneapolis, Minn.</i>	
24. REC'D BY REGISTRAR <i>DEC 12 1956</i>		REGISTRAR'S SIGNATURE <i>Am. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i>	

13033

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

IN THE YEAR 1956

1. NAME OF DECEASED (Print or Type)

JOHN W. BROWN

2. SEX

MALE

3. AGE

65

4. DATE OF DEATH

5. PLACE OF DEATH

6. CITY

7. COUNTY

8. STATE

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

BUREAU V. S.

DEC 18 1956

RECEIVED

NOTICE

This is to certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 18th day of December, 1956.

12040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emergency Hospital		d. STREET ADDRESS 6113 42th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosabel Middle De Vane Last De Vane		4. DATE OF DEATH Month DEC Day 31 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 15 Days 2 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Maultsy		14. MOTHER'S MAIDEN NAME Eliza King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT R. K. De Vane		Address Hyattsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) Hypertension			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 1 hr. 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-1-1956 to 12-31-1956 that I last saw the deceased alive on 12-31-1956 , and that death occurred at 1200 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Martin		ADDRESS (Street, city or town, state) G. SHAW ST. ANNAPOLIS, MD.	
PHYSICIAN'S NAME (Type) JAMES R. MARTIN		DATE SIGNED 12/31/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/57	22c. NAME OF CEMETERY OR CREMATORY Carver Creek Cemetery	22d. LOCATION (City, town, or county) (State) Council North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md	
24a. REC'D BY REGISTRAR JAN 5 1957		24b. REGISTRAR'S SIGNATURE John J. Lucha	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED John A. Smith		MARRIAGE MARRIED	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan 1, 1901	
RESIDENCE 1111 North Street		DATE OF DEATH Jan 1, 1957	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Home	
SEX Male		RACE White	
EDUCATION High School		OCCUPATION None	
MANNER OF DEATH Natural		PLACE OF INTERMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	

BUREAU V. 3

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

12035

Form 20 Film 209 1-16-57 ans

12068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Post Stockade TFGM</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VERNON</u> Middle <u>L.</u> Last <u>DILLARD</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Neg</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1931</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>30</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY <u>Soldier</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa.</u>	
13. FATHER'S NAME <u>Archie Dillard</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
14. MOTHER'S MAIDEN NAME <u>Mattie Buchanan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. 17. INFORMANT <u>Personnel Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet Wound of thorax with rupture of aorta</u> <u>919.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The prisoner was shot trying to escape from the post stockade</u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19 56</u> Hour <u>0900</u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>POST STOCKADE</u>		20f. (City or town) <u>Fort George G. Meade, Md.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>0930 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Robertson Capt MC</u>		ADDRESS (Street, city or town, state) <u>2101-1 USAH Ft Meade, Md</u> DATE SIGNED <u>30 Dec 56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN G. ROBERTSON, CAPT, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u> </u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Phillips</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburg Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St</u>		24a. REC'D BY REGISTRAR DATE <u>31 Dec 56</u>	
ADDRESS <u>Baltimore, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

JAN 3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12036¹⁶

Reg. Dist. No. 52

12069

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>friendship</i>		LENGTH OF STAY (in this place) <i>67 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>friendship md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Jeannette H. Dorsey</i>				<i>12 8 56</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>June 4, 1889</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H-W</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas B. Hood</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Rachel Ann Tucker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. Thomas H. Dorsey, Friendship</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
465X IMMEDIATE CAUSE (A)				<i>Infant of left lung</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/13</i>, 19<i>56</i>, to <i>12/18</i>, 19<i>56</i>, that I last saw the deceased alive on <i>12/17</i>, 19<i>56</i>, and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>H. W. Ward</i>				DATE SIGNED <i>12/18/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				24. REC'D BY REGISTRAR			
DATE THEREOF <i>12/10/56</i>		NAME OF CEMETERY OR CREMATORY <i>Friendship</i>		LOCATION (City, town, or county) (State) <i>Friendship Md.</i>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>James L. Hutchings</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Hutchings</i>		ADDRESS	
DATE <i>12/18/56</i>		<i>Shirley Dent</i>					

43438

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

BUREAU V. B.

DEC 17 1956

RECEIVED

RECEIVED
BALTIMORE, MD.
DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR
1000 CALVERT STREET
BALTIMORE, MD. 21205
TELEPHONE 633-1111
TELETYPE 633-1111
FAX 633-1111
HOURS: 9:00 AM - 5:00 PM
MONDAY - FRIDAY
SATURDAY 9:00 AM - 12:00 PM
SUNDAY 12:00 PM - 5:00 PM

12041

CERTIFICATE OF DEATH

12037

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>St Stephens Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>N</u> Last <u>DRAPER</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1912</u>	
9. AGE (In years last birthday) <u>44 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>West, Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mr. Raymond L. Draper - Husband - same as # 2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>genl. carcinomatosis</u> DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of cervix</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 25, 1955</u> , to <u>Dec. 5, 1956</u> , that I last saw the deceased alive on <u>Dec. 5, 1956</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. <u>Amos Garrett Blvd, Annapolis, Md.</u>				12/7/56			
PHYSICIAN'S NAME (Type) <u>S. Borssuck MD</u> <u>Amos Garrett Blvd, Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, Md.</u>				24a. REC'D BY REGISTRAR DATE			
24b. REGISTRAR'S SIGNATURE <u>S. Borssuck</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riv. Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bay & Harlem Rds.		d. STREET ADDRESS Bay & Harlem Rds.	
3. NAME OF DECEASED (Type or print) First HENRY Middle DURNER Last DURNER		4. DATE OF DEATH Month DEC. Day 19 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACK FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY VA. R.R.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SAMUEL		14. MOTHER'S MAIDEN NAME MARY WATTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 YEARS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB , 1956, to DEC. 19 , 1956, that I last saw the deceased alive on DEC. 19 , 1956, and that death occurred at 10:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Brady Smith M.D.		ADDRESS (Street, city or town, state) RIVIERA BEACH, MA	
PHYSICIAN'S NAME (Type) J. BRADY SMITH		DATE SIGNED 12/20/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-22-56	22c. NAME OF CEMETERY OR CREMATORY GLLEN HAVEN	22d. LOCATION (City, town, or county) (State) MA 01110
23. FUNERAL DIRECTOR'S SIGNATURE McGilly ADDRESS FUNERAL HOME		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE L. J. D. Allen

DEC 26 1956

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
J. BRADY SMITH		41		Male		White		Dec 18 1956		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Residence	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Physician		Baltimore, Md.	
Date of Birth		Date of Death		Time of Death		Hour		Minute		Second	
1915		1956		10:00		10		00		00	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
DEC 26 1956
BUREAU V. 3

12071 CERTIFICATE OF DEATH

12039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harundale		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) Aida Marie Eakin		4. DATE OF DEATH December 17th. 19 56	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/89
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife/Clerk (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Drug store	11. BIRTHPLACE (State or foreign country) Industry, Pennsylvania.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Olive E. Aber	
14. MOTHER'S MAIDEN NAME Lydia Walton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 202-28-4492		17. INFORMANT Mrs. Blanche E. McCormick (Daughter).	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/2/56 , 19____, to 12/17/56 , 19____, that I last saw the deceased alive on 12/15/56 , 19____, and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		DATE SIGNED 12/17/56	
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20/56	
22c. NAME OF CEMETERY OR CREMATORY Beaver Cemetery		22d. LOCATION (City, town, or county) (State) Beaver, Beaver Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Smith		24a. REC'D BY REGISTRAR DEC 19 1956	
ADDRESS Glen Burnie, Maryland		24b. REGISTRAR'S SIGNATURE L. J. Kelly	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12042 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A. A. CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL. 1	
4. DATE OF DEATH Month 12 Day 27 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Everett Middle Ellsworth Last Edelen	4. DATE OF DEATH Month 12 Day 27 Year 1956		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME --		14. MOTHER'S MAIDEN NAME --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel May Edelen		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis DUE TO (c) 1956			INTERVAL BETWEEN ONSET AND DEATH 1956
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 1955, to Dec , 1956, that I last saw the deceased alive on 12/27/56 , 1956, and that death occurred at A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Linhardt		ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED 12/27/56	
PHYSICIAN'S NAME (Type) E. Linhardt		Annapolis - MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/56	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Maryland	
24a. REC'D BY REGISTRAR DEC 27, 56		24b. REGISTRAR'S SIGNATURE Wm. French	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15013 CERTIFICATE OF DEATH

PLACE OF DEATH & COUNTY		HUSBAND	
A full and true statement of the facts and circumstances attending the death of the deceased, as far as known to the declarant, should be given in this space.		A full and true statement of the facts and circumstances attending the death of the deceased, as far as known to the declarant, should be given in this space.	
DECEASED'S NAME (Last, first, and middle name)		DECEASED'S NAME (Last, first, and middle name)	
AGE (In years, months, and days)		AGE (In years, months, and days)	
SEX (Male or Female)		SEX (Male or Female)	
RACE (Caucasian, Negro, or Other)		RACE (Caucasian, Negro, or Other)	
EDUCATION (Elementary, High School, College, or Other)		EDUCATION (Elementary, High School, College, or Other)	
OCCUPATION (In full, including branch or department)		OCCUPATION (In full, including branch or department)	
MARITAL STATUS (Single, Married, Widowed, or Divorced)		MARITAL STATUS (Single, Married, Widowed, or Divorced)	
DATE OF DEATH (Month, day, and year)		DATE OF DEATH (Month, day, and year)	
PLACE OF DEATH (In full, including street, city, county, and state)		PLACE OF DEATH (In full, including street, city, county, and state)	
CAUSE OF DEATH (In full, including immediate and remote causes)		CAUSE OF DEATH (In full, including immediate and remote causes)	
MANNER OF DEATH (Natural, Accidental, or Suicidal)		MANNER OF DEATH (Natural, Accidental, or Suicidal)	
SIGNATURE OF DECLARANT (In full, including name and address)		SIGNATURE OF DECLARANT (In full, including name and address)	
DATE OF SIGNATURE (Month, day, and year)		DATE OF SIGNATURE (Month, day, and year)	
WITNESSES (In full, including names and addresses)		WITNESSES (In full, including names and addresses)	
REGISTRATION (In full, including name and address)		REGISTRATION (In full, including name and address)	
FILING (In full, including name and address)		FILING (In full, including name and address)	
RECEIPT (In full, including name and address)		RECEIPT (In full, including name and address)	

RECEIVED
DEC 31 1956
BUREAU V. S.

THIS CERTIFICATE IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN THE TIME LIMITS SPECIFIED IN THE MARYLAND DEATH ACT OF 1903, AS AMENDED.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12041 *24*

Reg. Dist. No.

12072

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN lb Few seconds			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reese Rd. State Rd. # 554				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward HEALY ERISMAN				4. DATE OF DEATH 12/9/56 Month 12 Day 9 Year 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/23	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 32 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Employee Taverns and Grills				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Edward Hugh Erisman				14. MOTHER'S MAIDEN NAME Anna Healey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. Wrold No. II		17. INFORMANT Mrs. Emily E. Erisman - Fernhill Rd., Orchard Beach Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Automobile accident (no eye witness)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1/15 A.M. 12/9/56 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 554	
				20f. (City or town) Severn (County) A.A. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) Catonsville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Chm. J. Lickner & Sons - Baets 17 Md				24a. REC'D BY REGISTRAR Dec 10 1956		24b. REGISTRAR'S SIGNATURE <i>L. J. Sedlitz</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		Male		White		12/11/56		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
1234 E. Baltimore St.		Teacher		Heart Disease		Natural		Hypertension, Diabetes		None	
FATHER		MOTHER		SPOUSE		CHILDREN		PREVIOUS ILLNESS		TREATMENT	
John H. Harris		Mary E. Harris		Elizabeth Harris		James H. Harris		None		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MILITARY SERVICE		RELIGION		POLITICAL AFFILIATION	
12/11/11		Baltimore, Md.		High School		None		Catholic		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
12/11/56		Home		Heart Disease		Natural		Hypertension, Diabetes		None	
FATHER		MOTHER		SPOUSE		CHILDREN		PREVIOUS ILLNESS		TREATMENT	
John H. Harris		Mary E. Harris		Elizabeth Harris		James H. Harris		None		None	

BUREAU V. 3

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12042

12073 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1609 Church Street				d. STREET ADDRESS 1609 Church St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Esterka Last Esterka				4. DATE OF DEATH Month 12 Day 11 Year 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/83		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EUROPE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Family Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive cardiac disease DUE TO vascular disease (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 50 , to Dec 14 , 19 56 , that I last saw the deceased alive on Dec 13 , 19 56 , and that death occurred at 1000 M, from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE Philip H. Keister		M.D. 302 Patapasco Ave		ADDRESS (Street, city or town, state) Baltimore 25 Md			
PHYSICIAN'S NAME (Type) PHILIP H. KEISTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home				ADDRESS 130 E. Fort Ave. #30		24a. REC'D BY REGISTRAR DEC 17 1956	
				24b. REGISTRAR'S SIGNATURE She Whitson			

BUREAU V. 3

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12043

12074

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1005 Tiffany Court	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Galloway		4. DATE OF DEATH Month 12 Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/85
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None listed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Galloway		14. MOTHER'S MAIDEN NAME Priscilla Galloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. 022x	
17. INFORMANT Crownsville State Hospital Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage DUE TO (b) Ruptured Aneurism of the Aorta DUE TO (c) Senility and Syphilis	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senility and Syphilis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville, Md.	
20e. (City or town) Crownsville, Md.		20f. (County) (State)	
21. I certify that I attended the deceased from 12/20 , 19 56 , to 12/24 , 19 56 , that I last saw the deceased alive on 12/21 , 19 56 , and that death occurred at 4:00a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel M. Mapp		DATE SIGNED 12/24/56	
PHYSICIAN'S NAME (Type) Lionel M. Mapp, M. D.		ADDRESS (Street, city or town, state) Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/27/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lure		24a. REC'D BY REGISTRAR DEC 28 1956	
ADDRESS 802 Madison Ave		24b. REGISTRAR'S SIGNATURE J. M. Jones	

CERTIFICATE OF DEATH

1-1-1956

1. NAME OF DECEASED JAMES ALFRED		2. SEX Male		3. AGE 30	
4. DATE OF DEATH 12/20/55		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1945		15. NAME OF SPOUSE Mary Jane	
16. NAME OF FATHER John A.		17. NAME OF MOTHER Elizabeth		18. NAME OF BIRTHPLACE Baltimore, Md.	
19. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		20. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		21. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
22. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		23. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		24. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
25. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		26. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		27. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
28. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		29. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		30. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
31. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		32. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		33. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
34. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		35. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		36. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
37. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		38. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		39. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
40. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		41. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		42. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
43. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		44. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		45. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
46. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		47. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		48. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
49. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		50. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		51. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
52. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		53. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		54. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
55. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		56. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		57. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
58. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		59. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		60. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
61. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		62. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		63. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
64. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		65. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		66. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
67. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		68. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		69. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
70. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		71. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		72. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
73. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		74. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		75. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
76. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		77. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		78. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
79. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		80. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		81. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
82. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		83. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		84. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
85. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		86. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		87. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
88. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		89. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		90. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
91. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		92. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		93. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
94. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		95. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		96. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
97. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		98. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		99. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
100. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		101. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		102. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	

RECEIVED
DEC 28 1955
BUREAU V. 2

12043

12044

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A.C.O.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>A.A.C.O.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Pasadena</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural, give location) <u>Box 127 - Ventnor</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>waiter. John Golebiewski</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12. 24 1956</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M.</u>	8. DATE OF BIRTH: <u>Sept. 28, 1902</u>	9. AGE last birthday: <u>54</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Building</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Joseph Golebiewski</u>				14. MOTHER'S MAIDEN NAME: <u>Tillie Krzykowski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>(If Yes, give war or dates of service)</u>		17. INFORMANT & ADDRESS: <u>Mary Waglewicz Golebiewski (same)</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause		(a) <u>CORONARY DISEASE.</u>		Sudden.	
DUE TO					
Antecedent cause(s)		(b) <u>DUE TO</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>E. Lee Hunt</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-20-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>George J. Gance</u>		24. FUNERAL DIRECTOR ADDRESS <u>Anne Arundel Co. 4001 Ritchie Hwy.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12075

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundal</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundal</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7416 Fort Smallwood Road</u>		d. STREET ADDRESS <u>7416 Fort Smallwood Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kathering Grabowski</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Jorzak</u>		14. MOTHER'S MAIDEN NAME <u>Kathering ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Frank Grabowski-7416 Fort Smallwood Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiac Vascular Disease</u> DUE TO (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>DEC 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>56</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u> DATE SIGNED <u>12/31/56</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		<u>RIVIERA BEACH, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery Baltimore, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran-3000 E. Baltimore St.</u>		24a. RECEIVED BY REGISTRAR <u>JAN 2 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12046

12076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7yrs. 5mos.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 817 Warner Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alberta Middle Gray Last Gray				4. DATE OF DEATH Month 12 Day 31 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/11	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Clint Mitchell				14. MOTHER'S MAIDEN NAME Anna (Last name not given)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
				Address Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 025x IMMEDIATE CAUSE (a) Dehydration and Malnutrition with Hypostatic Pneumonia DUE TO General Paresis of the Insane Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy, Hypertensive Cardiovascular Disease & Decubitus ulcers							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10 , 19 56 , to 12/31 , 19 56 , that I last saw the deceased alive on 12/28 , 19 56 , and that death occurred at 3:00a. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 12/31/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Isaac L. Broun				ADDRESS 108 W. MONTGOMERY ST (30)		24a. REC'D BY REGISTRAR DATE 1/2/57	
				24b. REGISTRAR'S SIGNATURE			

325 IV

1

55

C1924

10

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

2

BUREAU V. S.

JAN 3 1957

RECEIVED

12077

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b 31yrs. 3mos. 1day		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1135 Stockton Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia Middle Last Gross		4. DATE OF DEATH Month 12 Day 26 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not listed
9. AGE (In years last birthday) 72? yrs.		IF UNDER 1 YEAR: Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not listed		14. MOTHER'S MAIDEN NAME Not listed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal Failure DUE TO (c) Hypertensive Cardiovascular Disease, Hypostatic Pneumonia, Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/5 , 19 56 , to 12/26 , 19 56 , that I last saw the deceased alive on 12/26 , 19 56 , and that death occurred at 9:45a. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 12/26/56			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-4-56	
22c. NAME OF CEMETERY OR CREMATORY University of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR A. M. Joyce		24b. REGISTRAR'S SIGNATURE A. M. Joyce	
DATE 10 1957			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
HOME		MARRIED	
DATE OF DEATH		DATE OF MARRIAGE	
JAN 10 1957		JAN 10 1957	
TIME OF DEATH		TIME OF MARRIAGE	
11:30 AM		11:30 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF BIRTH	
JAN 10 1957		JAN 10 1957	
TIME OF BIRTH		TIME OF BIRTH	
11:30 AM		11:30 AM	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
DATE OF DEATH		DATE OF DEATH	
JAN 10 1957		JAN 10 1957	
TIME OF DEATH		TIME OF DEATH	
11:30 AM		11:30 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF BIRTH	
JAN 10 1957		JAN 10 1957	
TIME OF BIRTH		TIME OF BIRTH	
11:30 AM		11:30 AM	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
DATE OF DEATH		DATE OF DEATH	
JAN 10 1957		JAN 10 1957	
TIME OF DEATH		TIME OF DEATH	
11:30 AM		11:30 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF BIRTH	
JAN 10 1957		JAN 10 1957	
TIME OF BIRTH		TIME OF BIRTH	
11:30 AM		11:30 AM	

RECEIVED

JAN 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&20 Film G208 12-28-56

12078

CERTIFICATE OF DEATH

12047

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENOCK				c. LENGTH OF STAY IN 1b 3 MO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Greenock			
3. NAME OF DECEASED (Type or print) First Middle Last WARREN RODNEY GROSS				4. DATE OF DEATH Month Day Year DEC. 5 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/55	
9. AGE (In years last birthday) 18 MO		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME ALBERT GROSS				14. MOTHER'S MAIDEN NAME Blondell Chapman Gross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Blondell Gross, Tracy's Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stove exploded setting house afire and house burn to the ground - child left accidentally in house (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House burn to ground and child accidentally left in house			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 5 PM p. m. 12/5/56 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Greenock				20g. P.O. Lothian P.O.		20h. (County) (State) A.A. Maryland	
21. I certify that I attended the deceased from not at all , 19____, to _____, 19____, that I last saw the deceased alive on not at all , 19____, and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lothian, Md. DATE SIGNED 12-5-56 ACTUAL SIGNATURE Emily H. Whim M.D. acting coroner. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/56		22c. NAME OF CEMETERY OR CREMATORY Adams Chapel		22d. LOCATION (City, town, or county) (State) Lothian Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty				24a. REC'D BY REGISTRAR 12-5-56		24b. REGISTRAR'S SIGNATURE B. J. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

DEC 12 1956

BUREAU V. S.

RECEIVED

12044

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Revell Station, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>YEWELL</u> Middle <u>HALL</u> Last				4. DATE OF DEATH Month <u>DEC</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10 1904</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Y. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Lottie V. Van Pelt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		(If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Gertrude Frantom Annapolis Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs + 1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12/12/</u> , 19 <u>56</u> , to <u>12/13/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-13-</u> 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/13/56</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				ANAPOLIS, MD.			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-17-56</u>		<u>U.S. National Cem.</u>		<u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>John M. Taylor Son Annapolis Md</u>				<u>12/17/56</u>		<u>O. J. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Y. White</i>		AGE <i>45</i>	
SEX <i>Male</i>		DATE OF BIRTH <i>Oct 10 1902</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Engineer</i>		RESIDENCE <i>1234 N. Main St.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>Dec 18 1956</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF DECEASED <i>John Y. White</i>	
SIGNATURE OF WITNESS <i>Dr. J. H. Smith</i>		SIGNATURE OF DECEASED <i>John Y. White</i>	

BUREAU V. 2

DEC 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12049

12079

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 9mos. 16days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 242 N. Spring Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Maude Middle Haney Last Haney				4. DATE OF DEATH Month 12 Day 7 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 1899 57	
9. AGE (In years (Birth day) yrs. Months Days Hours Min. 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Mahala Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Crownsville State Hospital		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Intestinal Obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal Obstruction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9 , 1956, to 12/7 , 1956, that I last saw the deceased alive on 12/7 , 1956, and that death occurred at 4:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 12/7/56							
ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville, Md. DATE SIGNED 12/7/56							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-11-56		22c. NAME OF CEMETERY OR CREMATORY Balto		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis A. Henry				ADDRESS 802 Balto		24a. REC'D BY REGISTRAR DATE 12/10/56	
				24b. REGISTRAR'S SIGNATURE L. M. Joyce			

CERTIFICATE OF DEATH

1907

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		Male		White		Roman Catholic	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
Dec 11 1956		Home		Heart Disease		Natural		Coronary Artery Disease	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARITAL STATUS	
Jan 15 1911		Baltimore, Md.		High School		Teacher		Married	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE		MANNER OF DEATH OF SPOUSE	
May 10 1935		Mary H. Harris		Dec 15 1955		Heart Disease		Natural	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH	
Dec 12 1956		St. Mary's Church		John J. Harris		Rev. J. J. Harris		St. Mary's Church	
DATE OF SIGNATURE		NAME OF SIGNER		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
Dec 11 1956		James H. Harris		John J. Harris		John J. Harris		John J. Harris	

BUREAU V. 2

DEC 11 1956

RECEIVED

12045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracey Landing</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>				d. STREET ADDRESS <u>1</u>		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Hopkins</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E. Taylor Churn</u>		11. BIRTHPLACE (State or foreign country) <u>Liver Pool, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Annie Hopkins - Tracey Landing, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>December 24, 1956</u> , to <u>Dec. 26, 1956</u> , that I last saw the deceased alive on <u>Dec. 26, 1956</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emil H. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Sutton, Md.</u> DATE SIGNED <u>12-27-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>12-27-56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>John J. Lench</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 10 1957</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md</i></p>	
<p>10. DATE OF BIRTH <i>Jan 15 1912</i></p>		<p>11. TIME OF BIRTH <i>10:30 AM</i></p>		<p>12. PLACE OF BIRTH <i>Baltimore, Md</i></p>	
<p>13. NAME OF FATHER <i>John Doe</i></p>		<p>14. NAME OF MOTHER <i>John Doe</i></p>		<p>15. NAME OF SPOUSE <i>John Doe</i></p>	
<p>16. NAME OF CHILD <i>John Doe</i></p>		<p>17. NAME OF CHILD <i>John Doe</i></p>		<p>18. NAME OF CHILD <i>John Doe</i></p>	
<p>19. NAME OF CHILD <i>John Doe</i></p>		<p>20. NAME OF CHILD <i>John Doe</i></p>		<p>21. NAME OF CHILD <i>John Doe</i></p>	
<p>22. NAME OF CHILD <i>John Doe</i></p>		<p>23. NAME OF CHILD <i>John Doe</i></p>		<p>24. NAME OF CHILD <i>John Doe</i></p>	
<p>25. NAME OF CHILD <i>John Doe</i></p>		<p>26. NAME OF CHILD <i>John Doe</i></p>		<p>27. NAME OF CHILD <i>John Doe</i></p>	
<p>28. NAME OF CHILD <i>John Doe</i></p>		<p>29. NAME OF CHILD <i>John Doe</i></p>		<p>30. NAME OF CHILD <i>John Doe</i></p>	
<p>31. NAME OF CHILD <i>John Doe</i></p>		<p>32. NAME OF CHILD <i>John Doe</i></p>		<p>33. NAME OF CHILD <i>John Doe</i></p>	
<p>34. NAME OF CHILD <i>John Doe</i></p>		<p>35. NAME OF CHILD <i>John Doe</i></p>		<p>36. NAME OF CHILD <i>John Doe</i></p>	
<p>37. NAME OF CHILD <i>John Doe</i></p>		<p>38. NAME OF CHILD <i>John Doe</i></p>		<p>39. NAME OF CHILD <i>John Doe</i></p>	
<p>40. NAME OF CHILD <i>John Doe</i></p>		<p>41. NAME OF CHILD <i>John Doe</i></p>		<p>42. NAME OF CHILD <i>John Doe</i></p>	
<p>43. NAME OF CHILD <i>John Doe</i></p>		<p>44. NAME OF CHILD <i>John Doe</i></p>		<p>45. NAME OF CHILD <i>John Doe</i></p>	
<p>46. NAME OF CHILD <i>John Doe</i></p>		<p>47. NAME OF CHILD <i>John Doe</i></p>		<p>48. NAME OF CHILD <i>John Doe</i></p>	
<p>49. NAME OF CHILD <i>John Doe</i></p>		<p>50. NAME OF CHILD <i>John Doe</i></p>		<p>51. NAME OF CHILD <i>John Doe</i></p>	
<p>52. NAME OF CHILD <i>John Doe</i></p>		<p>53. NAME OF CHILD <i>John Doe</i></p>		<p>54. NAME OF CHILD <i>John Doe</i></p>	
<p>55. NAME OF CHILD <i>John Doe</i></p>		<p>56. NAME OF CHILD <i>John Doe</i></p>		<p>57. NAME OF CHILD <i>John Doe</i></p>	
<p>58. NAME OF CHILD <i>John Doe</i></p>		<p>59. NAME OF CHILD <i>John Doe</i></p>		<p>60. NAME OF CHILD <i>John Doe</i></p>	
<p>61. NAME OF CHILD <i>John Doe</i></p>		<p>62. NAME OF CHILD <i>John Doe</i></p>		<p>63. NAME OF CHILD <i>John Doe</i></p>	
<p>64. NAME OF CHILD <i>John Doe</i></p>		<p>65. NAME OF CHILD <i>John Doe</i></p>		<p>66. NAME OF CHILD <i>John Doe</i></p>	
<p>67. NAME OF CHILD <i>John Doe</i></p>		<p>68. NAME OF CHILD <i>John Doe</i></p>		<p>69. NAME OF CHILD <i>John Doe</i></p>	
<p>70. NAME OF CHILD <i>John Doe</i></p>		<p>71. NAME OF CHILD <i>John Doe</i></p>		<p>72. NAME OF CHILD <i>John Doe</i></p>	
<p>73. NAME OF CHILD <i>John Doe</i></p>		<p>74. NAME OF CHILD <i>John Doe</i></p>		<p>75. NAME OF CHILD <i>John Doe</i></p>	
<p>76. NAME OF CHILD <i>John Doe</i></p>		<p>77. NAME OF CHILD <i>John Doe</i></p>		<p>78. NAME OF CHILD <i>John Doe</i></p>	
<p>79. NAME OF CHILD <i>John Doe</i></p>		<p>80. NAME OF CHILD <i>John Doe</i></p>		<p>81. NAME OF CHILD <i>John Doe</i></p>	
<p>82. NAME OF CHILD <i>John Doe</i></p>		<p>83. NAME OF CHILD <i>John Doe</i></p>		<p>84. NAME OF CHILD <i>John Doe</i></p>	
<p>85. NAME OF CHILD <i>John Doe</i></p>		<p>86. NAME OF CHILD <i>John Doe</i></p>		<p>87. NAME OF CHILD <i>John Doe</i></p>	
<p>88. NAME OF CHILD <i>John Doe</i></p>		<p>89. NAME OF CHILD <i>John Doe</i></p>		<p>90. NAME OF CHILD <i>John Doe</i></p>	
<p>91. NAME OF CHILD <i>John Doe</i></p>		<p>92. NAME OF CHILD <i>John Doe</i></p>		<p>93. NAME OF CHILD <i>John Doe</i></p>	
<p>94. NAME OF CHILD <i>John Doe</i></p>		<p>95. NAME OF CHILD <i>John Doe</i></p>		<p>96. NAME OF CHILD <i>John Doe</i></p>	
<p>97. NAME OF CHILD <i>John Doe</i></p>		<p>98. NAME OF CHILD <i>John Doe</i></p>		<p>99. NAME OF CHILD <i>John Doe</i></p>	
<p>100. NAME OF CHILD <i>John Doe</i></p>		<p>101. NAME OF CHILD <i>John Doe</i></p>		<p>102. NAME OF CHILD <i>John Doe</i></p>	

BUREAU V. S.

JAN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12051
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <u>ANN E - ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>SAME</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	c. LENGTH OF STAY IN 1b <u>ALL LIFE</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAME</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE T - Box - 174A</u>		d. STREET ADDRESS <u>SAME</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>KENNETH - BERNARD - JONES</u> First Middle Last		4. DATE OF DEATH <u>DECEMBER - 24</u> 19 <u>56</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/06</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINCE-GEORGE HOSPITAL</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JESSE - JONES</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE - MAE - WEST</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILLIE - MAE - WEST JONES (MOTHER)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), <u>SUFFOCATION</u> 924.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BABY SLEPT BETWEEN MOTHER AND ANOTHER CHILD</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> o. m. <u>12/24</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> <u>HOME</u> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>LAUREL - A.A.</u>		20f. (City or town) (County) (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GUSTAVE - H. FAUBERT - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/24/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Church</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. McQuinn</u>		ADDRESS <u>1820 - 9th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Shapp</u>	

2077258 XV4

Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED LAST, FIRST, MIDDLE SUFFIX SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		2. DATE OF DEATH MONTH DAY YEAR	
3. PLACE OF DEATH STREET, CITY, STATE, ZIP		4. TIME OF DEATH HOUR MINUTE	
5. OCCASION OF DEATH <input type="checkbox"/> SUICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> OTHER		6. CAUSE OF DEATH PRIMARY SECONDARY	
7. MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> UNNATURAL		8. SIGNATURE OF EXAMINER TITLE	
9. SIGNATURE OF WITNESS TITLE		10. SIGNATURE OF CORONER TITLE	
11. SIGNATURE OF JURY TITLE		12. SIGNATURE OF JURY TITLE	
13. SIGNATURE OF JURY TITLE		14. SIGNATURE OF JURY TITLE	
15. SIGNATURE OF JURY TITLE		16. SIGNATURE OF JURY TITLE	
17. SIGNATURE OF JURY TITLE		18. SIGNATURE OF JURY TITLE	
19. SIGNATURE OF JURY TITLE		20. SIGNATURE OF JURY TITLE	
21. SIGNATURE OF JURY TITLE		22. SIGNATURE OF JURY TITLE	
23. SIGNATURE OF JURY TITLE		24. SIGNATURE OF JURY TITLE	
25. SIGNATURE OF JURY TITLE		26. SIGNATURE OF JURY TITLE	
27. SIGNATURE OF JURY TITLE		28. SIGNATURE OF JURY TITLE	
29. SIGNATURE OF JURY TITLE		30. SIGNATURE OF JURY TITLE	
31. SIGNATURE OF JURY TITLE		32. SIGNATURE OF JURY TITLE	
33. SIGNATURE OF JURY TITLE		34. SIGNATURE OF JURY TITLE	
35. SIGNATURE OF JURY TITLE		36. SIGNATURE OF JURY TITLE	
37. SIGNATURE OF JURY TITLE		38. SIGNATURE OF JURY TITLE	
39. SIGNATURE OF JURY TITLE		40. SIGNATURE OF JURY TITLE	
41. SIGNATURE OF JURY TITLE		42. SIGNATURE OF JURY TITLE	
43. SIGNATURE OF JURY TITLE		44. SIGNATURE OF JURY TITLE	
45. SIGNATURE OF JURY TITLE		46. SIGNATURE OF JURY TITLE	
47. SIGNATURE OF JURY TITLE		48. SIGNATURE OF JURY TITLE	
49. SIGNATURE OF JURY TITLE		50. SIGNATURE OF JURY TITLE	
51. SIGNATURE OF JURY TITLE		52. SIGNATURE OF JURY TITLE	
53. SIGNATURE OF JURY TITLE		54. SIGNATURE OF JURY TITLE	
55. SIGNATURE OF JURY TITLE		56. SIGNATURE OF JURY TITLE	
57. SIGNATURE OF JURY TITLE		58. SIGNATURE OF JURY TITLE	
59. SIGNATURE OF JURY TITLE		60. SIGNATURE OF JURY TITLE	
61. SIGNATURE OF JURY TITLE		62. SIGNATURE OF JURY TITLE	
63. SIGNATURE OF JURY TITLE		64. SIGNATURE OF JURY TITLE	
65. SIGNATURE OF JURY TITLE		66. SIGNATURE OF JURY TITLE	
67. SIGNATURE OF JURY TITLE		68. SIGNATURE OF JURY TITLE	
69. SIGNATURE OF JURY TITLE		70. SIGNATURE OF JURY TITLE	
71. SIGNATURE OF JURY TITLE		72. SIGNATURE OF JURY TITLE	
73. SIGNATURE OF JURY TITLE		74. SIGNATURE OF JURY TITLE	
75. SIGNATURE OF JURY TITLE		76. SIGNATURE OF JURY TITLE	
77. SIGNATURE OF JURY TITLE		78. SIGNATURE OF JURY TITLE	
79. SIGNATURE OF JURY TITLE		80. SIGNATURE OF JURY TITLE	
81. SIGNATURE OF JURY TITLE		82. SIGNATURE OF JURY TITLE	
83. SIGNATURE OF JURY TITLE		84. SIGNATURE OF JURY TITLE	
85. SIGNATURE OF JURY TITLE		86. SIGNATURE OF JURY TITLE	
87. SIGNATURE OF JURY TITLE		88. SIGNATURE OF JURY TITLE	
89. SIGNATURE OF JURY TITLE		90. SIGNATURE OF JURY TITLE	
91. SIGNATURE OF JURY TITLE		92. SIGNATURE OF JURY TITLE	
93. SIGNATURE OF JURY TITLE		94. SIGNATURE OF JURY TITLE	
95. SIGNATURE OF JURY TITLE		96. SIGNATURE OF JURY TITLE	
97. SIGNATURE OF JURY TITLE		98. SIGNATURE OF JURY TITLE	
99. SIGNATURE OF JURY TITLE		100. SIGNATURE OF JURY TITLE	

BUREAU V. 8.

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12046 CERTIFICATE OF DEATH

12052

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>LAW</u> Last <u>LAW</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief K.R. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Conductor</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles C. Law Jr. (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-8</u> , 19 <u>56</u> , to <u>12-8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-8</u> , 19 <u>56</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>12-9-56</u> ACTUAL SIGNATURE <u>James R. Martin</u> M.D. <u>Quigley's</u> PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carrer Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Beltville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's & Sons Co.</u>			ADDRESS <u>300 4th St W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 1956</u>		
						24b. REGISTRAR'S SIGNATURE <u>Wm J. French</u>	

[illegible]

DEC 12 1956

RECEIVED

BUREAU V. S.

DEC 12 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12053

12081

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena P. O.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena P. O.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ft. Smallwood Rd.		d. STREET ADDRESS Ft. Smallwood Rd.	
3. NAME OF DECEASED (Type or print) Minnie M. Lennox		4. DATE OF DEATH Month December Day 15 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Talbot Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wesley Helsby		14. MOTHER'S MAIDEN NAME Mulligan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Jesse S. Lennox, Sr.		Address Pasadena P. O., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 1 hour 10 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 15, 1950 , to December 15, 1956 , that I last saw the deceased alive on December 15, 1956 , and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED Dec. 16, 1956	
PHYSICIAN'S NAME (Type) R. M. McLaughlin M.D.		Pasadena, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/56	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		ADDRESS 715 Light St.	
24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE L. J. DeLaney	
Baltimore-30, Md.			

CERTIFICATE OF DEATH

1951

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

<p>1. Name of deceased: Frederick E. S.</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1901</p>		<p>4. Place of birth: Massachusetts</p>	
<p>5. Date of death: 1951</p>		<p>6. Place of death: Massachusetts</p>	
<p>7. Cause of death: Heart failure</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: [Signature]</p>		<p>10. Signature of registrar: [Signature]</p>	
<p>11. Date of registration: 1951</p>		<p>12. Place of registration: Massachusetts</p>	

BUREAU V. 3

DEC 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12082

CERTIFICATE OF DEATH

12054

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Manor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magot/614mcHenry St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arnold</u>				d. STREET ADDRESS <u>Balto Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louisa Mary Long</u>				4. DATE OF DEATH Month Day Year <u>Dec. 27 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19, 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Bernard Fortman</u>				14. MOTHER'S MAIDEN NAME <u>Bernadine ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Son Francis J. Long</u>			
17. INFORMANT Address <u>Magothy Beach Arnold</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>56</u> , to <u>Dec 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 Dec</u> , 19 <u>56</u> , and that death occurred at <u>9:27</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>			
DATE SIGNED <u>12-27-56</u>							
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 29 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry F. Witzke</u> ADDRESS <u>4101 Edmondson</u>				24a. REC'D BY REGISTRAR <u>DATE 12-27-56</u>			
24b. REGISTRAR'S SIGNATURE <u>Harry F. Witzke</u>							

BUREAU V. 8

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12055

12047

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>				d. STREET ADDRESS <u>Lothian</u>			
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Anna</u> Last <u>Marruder</u>				4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Days Work</u>		11. BIRTHPLACE (State or foreign country) <u>Bristol, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David Bias</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Bias</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-34-6764</u>		17. INFORMANT <u>Joseph Maguder</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral hemorrhage</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>atherosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>56</u> to <u>Dec 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 1</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily H. Ingram</u> M.D.				ADDRESS (Street, city or town, state) <u>Lothian</u> DATE SIGNED <u>12-4-56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>EC 6</u> DATE <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. J. French</u>	

BUREAU V. S.

DEC 9 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Pasadena		c. LENGTH OF STAY IN 1b 26 y.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lake Shore Drive				d. STREET ADDRESS Same			
3. NAME OF DECEASED (Type or print) First Middle Last George Henry Mank				4. DATE OF DEATH Month Day Year December 9th. 19 56			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/94		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing and Heating Inspector		10b. KIND OF BUSINESS OR INDUSTRY A.A. Col Baltimore, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Henry Mank				14. MOTHER'S MAIDEN NAME Thereasa Keene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Robert Mank (son) RFD 5 Box 491 Pasadena Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH ?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/9/56	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 11, 1956	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. Glen Burnie Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE George J. Force				ADDRESS 4001 Ritchie Hgwy.		24a. REC'D BY REGISTRAR DATE 12/13/56	24b. REGISTRAR'S SIGNATURE L. J. DeLap

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male		AGE 45	
DATE OF DEATH 10/15/55		PLACE OF DEATH Home		CITY Baltimore	
OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF MEDICAL EXAMINER [Signature]		DATE 10/15/55		PLACE Baltimore	
SIGNATURE OF NEXT OF KIN [Signature]		DATE 10/15/55		PLACE Baltimore	
SIGNATURE OF CLERK [Signature]		DATE 10/15/55		PLACE Baltimore	

BUREAU V. 5

1956 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12057

12084

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 20yrs. 7mos. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 517 N. Carrollton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stephen Middle Matthews Last Matthews				4. DATE OF DEATH Month 12 Day 12 Year 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/20/99	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Virgil Matthews				14. MOTHER'S MAIDEN NAME Mary Etta Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hosp. Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c) Post dental infection, Dehydration							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/8 , 19 56 , to 12/12 , 19 56 , that I last saw the deceased alive on 12/12 , 19 56 , and that death occurred at 10:05 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 12/12/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-17-56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Alexander				ADDRESS 2700 Edmondson Ave		24a. REC'D BY REGISTRAR 26 M. Joyce	
24b. REGISTRAR'S SIGNATURE				DATE 12/17/56			

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12058

12048 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>B.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>432 State St.</u>				d. STREET ADDRESS <u>432 State St.</u>			
3. NAME OF DECEASED (Type or print) First <u>MAURICE</u> Middle <u>E.</u> Last <u>MEADE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1888</u>	9. AGE (In years last birthday) yrs. <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD G. MEADE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HUTCHINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-32-1909</u>		17. INFORMANT <u>FLORENCE MEADE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> <u>008X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 53</u> , 19____, to <u>12-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/20/56</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>F. Linhardt</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>12-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DEC 26 1956

RECEIVED

12086

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McKendree				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Francis Middle Medley Last Medley				4. DATE OF DEATH Month Dec. Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1896		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) T.B., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Medley				14. MOTHER'S MAIDEN NAME Mary Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Theresa Scott, Lothian, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH about 2 weeks	
21. I certify that I attended the deceased from 10-21 , 1956 , to 12-27 , 1956 , that I last saw the deceased alive on 12-26-56 , 19 56 , and that death occurred at 4:15 A.M., from the causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE A. T. Allen				ADDRESS (Street, city or town, state) 62 Cathedral Street, Annapolis, Md.			
PHYSICIAN'S NAME (Type) A. T. Allen				DATE SIGNED 2-5-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Piscataway, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty				ADDRESS Galesville, Md.		24a. REC'D BY REGISTRAR Feb 11 1957	
				24b. REGISTRAR'S SIGNATURE Ma Belle Dent			

1/27/57

mb

CERTIFICATE OF DEATH

Replacement certificate
Original apparently lost in mail - 2/11/57 -
MB.

BUREAU V. S.

FEB 11 1957

RECEIVED

12049 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Mayo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>D</u> Last <u>MORGAN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1912</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Morgan</u>	
14. MOTHER'S MAIDEN NAME <u>Mabel (Unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1929</u>	
16. SOCIAL SECURITY NO. <u>216-12-6941</u>		17. INFORMANT <u>Mrs. Elara W. Morgan- Wife- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>16 HOURS</u> <u>1 YEAR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 DEC., 1956</u> , to <u>19 DEC., 1956</u> , that I last saw the deceased alive on <u>19 DEC., 1956</u> , and that death occurred at <u>9⁰⁰ P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Edward Beck</u> M.D. <u>Southgate Ave</u> DATE SIGNED <u>12/21/56</u> PHYSICIAN'S NAME (Type) <u>Edward Beck MD</u> ADDRESS <u>Southgate Ave. Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>12-22-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>12/22/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. B. [Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

12087

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 467</u>				d. STREET ADDRESS <u>Box 467</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Richard A. Neale</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1870</u>	9. AGE (In years) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard A. Neale</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Boston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Jane Neale - Rt 1 Box 467 - Edgewater Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c) <u>331X</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sanity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-10-56</u> , 19 <u>56</u> , to <u>12-12-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-10-56</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.				ADDRESS (Street, city or town, state) <u>62 Cathedral</u> DATE SIGNED <u>12-14-56</u>			
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Reverville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis</u> ADDRESS <u>---</u>				24a. REC'D BY REGISTRAR <u>DEC 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Am J. Funch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Richard A. Neal

Richard A. Neal

7-1-1870

7-1-1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

BUREAU V. 3

DEC 26 1956

RECEIVED

Richard A. Neal
7-1-1870
1870

12088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 Sycamore Rd.</u>				d. STREET ADDRESS <u>112 Sycamore Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CATHERINE O'CONNOR</u>				4. DATE OF DEATH Month Day Year <u>12-7-56</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17-1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Parkinson</u>				14. MOTHER'S MAIDEN NAME <u>Clara Meekins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lawrence J. O'Connor</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 months</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 7</u> , 19 <u>56</u> , to <u>Dec 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>56</u> , and that death occurred at <u>3:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. J. Grimaldi</u>				ADDRESS (Street, city or town, state) <u>4609 Gar. Ridge Hwy</u>			
PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI</u>				DATE SIGNED <u>12-8-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>J. O'Connor</u>	
				DATE <u>10-10-56</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 6216 1-29-57 et

12050 CERTIFICATE OF DEATH

12062

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNAPOLIS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>710 Second St. 10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL HOSPITAL</u>				d. STREET ADDRESS <u>ANNAPOLIS MD.</u>			
3. NAME OF DECEASED (Type or print) <u>MARY FRANCES ELIZABETH</u> First Middle Last				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>Colored</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Sept 20 1929</u>			
9. AGE (In years last birthday) <u>27</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>EASTON MD.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Augustus McDaniel</u>				14. MOTHER'S MAIDEN NAME <u>Edna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219 324075</u>			
17. INFORMANT <u>JAMES HARRISON PARKER</u> Address <u>710 Second St. Annapolis MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>acute Cardiac Failure</u> (b) <u>myocardial Heart Disease</u> DUE TO <u>myocardial Heart Disease</u> (c) <u>myocardial Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-6-56</u> 19, to <u>12-10-56</u> 19, that I last saw the deceased alive on <u>12-10-56</u> 19, and that death occurred at <u>9:26</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.T. ALLEN</u>				ADDRESS (Street, city or town, state) <u>62 Chestnut St</u>			
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>				DATE SIGNED <u>12-14-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Adams Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galesville Md</u>				24a. REC'D BY REGISTRAR <u>JO</u> 24b. REGISTRAR'S SIGNATURE <u>U. D. ...</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN	
19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF HEALTH DEPARTMENT		23. SIGNATURE OF DISTRICT ATTORNEY		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF CLERK		27. SIGNATURE OF RECORDER	
28. SIGNATURE OF ARCHIVIST		29. SIGNATURE OF INDEXER		30. SIGNATURE OF LIBRARIAN	
31. SIGNATURE OF ASSISTANT		32. SIGNATURE OF CLERK		33. SIGNATURE OF RECORDER	
34. SIGNATURE OF ARCHIVIST		35. SIGNATURE OF INDEXER		36. SIGNATURE OF LIBRARIAN	
37. SIGNATURE OF ASSISTANT		38. SIGNATURE OF CLERK		39. SIGNATURE OF RECORDER	
40. SIGNATURE OF ARCHIVIST		41. SIGNATURE OF INDEXER		42. SIGNATURE OF LIBRARIAN	
43. SIGNATURE OF ASSISTANT		44. SIGNATURE OF CLERK		45. SIGNATURE OF RECORDER	
46. SIGNATURE OF ARCHIVIST		47. SIGNATURE OF INDEXER		48. SIGNATURE OF LIBRARIAN	
49. SIGNATURE OF ASSISTANT		50. SIGNATURE OF CLERK		51. SIGNATURE OF RECORDER	
52. SIGNATURE OF ARCHIVIST		53. SIGNATURE OF INDEXER		54. SIGNATURE OF LIBRARIAN	
55. SIGNATURE OF ASSISTANT		56. SIGNATURE OF CLERK		57. SIGNATURE OF RECORDER	
58. SIGNATURE OF ARCHIVIST		59. SIGNATURE OF INDEXER		60. SIGNATURE OF LIBRARIAN	
61. SIGNATURE OF ASSISTANT		62. SIGNATURE OF CLERK		63. SIGNATURE OF RECORDER	
64. SIGNATURE OF ARCHIVIST		65. SIGNATURE OF INDEXER		66. SIGNATURE OF LIBRARIAN	
67. SIGNATURE OF ASSISTANT		68. SIGNATURE OF CLERK		69. SIGNATURE OF RECORDER	
70. SIGNATURE OF ARCHIVIST		71. SIGNATURE OF INDEXER		72. SIGNATURE OF LIBRARIAN	
73. SIGNATURE OF ASSISTANT		74. SIGNATURE OF CLERK		75. SIGNATURE OF RECORDER	
76. SIGNATURE OF ARCHIVIST		77. SIGNATURE OF INDEXER		78. SIGNATURE OF LIBRARIAN	
79. SIGNATURE OF ASSISTANT		80. SIGNATURE OF CLERK		81. SIGNATURE OF RECORDER	
82. SIGNATURE OF ARCHIVIST		83. SIGNATURE OF INDEXER		84. SIGNATURE OF LIBRARIAN	
85. SIGNATURE OF ASSISTANT		86. SIGNATURE OF CLERK		87. SIGNATURE OF RECORDER	
88. SIGNATURE OF ARCHIVIST		89. SIGNATURE OF INDEXER		90. SIGNATURE OF LIBRARIAN	
91. SIGNATURE OF ASSISTANT		92. SIGNATURE OF CLERK		93. SIGNATURE OF RECORDER	
94. SIGNATURE OF ARCHIVIST		95. SIGNATURE OF INDEXER		96. SIGNATURE OF LIBRARIAN	
97. SIGNATURE OF ASSISTANT		98. SIGNATURE OF CLERK		99. SIGNATURE OF RECORDER	
100. SIGNATURE OF ARCHIVIST		101. SIGNATURE OF INDEXER		102. SIGNATURE OF LIBRARIAN	

RECEIVED
DEC 21 1895
BUREAU V. S.

12063

12089

CERTIFICATE OF DEATH

Reg. Dist. No. 78

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gambrills</u>		LENGTH OF STAY (In this place) <u>32 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gambrills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Florida & California Avenues</u>				STREET ADDRESS (If rural give location) <u>Florida & California Avenues</u>			
3. NAME OF DECEASED (Type or Print) <u>SAMUEL LOUIS PETERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 24, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 1, 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kramer Company</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Peters</u>				14. MOTHER'S MAIDEN NAME <u>Ida Boyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-7267</u>		17. INFORMANT & ADDRESS <u>Mrs. Carrie A. Peters. Same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MO</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchogenic Carcinoma</u>						<u>3 MO</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>Dec 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edmund J. Sherritt</u>				ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>12-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REG'D BY REGISTRAR <u>DEC 28 1956</u>		REGISTRAR'S SIGNATURE <u>E. M. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard F. Sington</u>		ADDRESS <u>Ill. Burnie, Md.</u>	

CERTIFICATE OF DEATH

Be-10-10-10

1. LOCAL BOARD OF HEALTH OR DISTRICT

2. PLACE OF DEATH

MARYLAND

3. NAME AND ADDRESS

4. DATE OF DEATH

5. TIME OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. SEX

13. AGE

14. OCCUPATION

15. CAUSE OF DEATH

16. PLACE OF BIRTH

17. DATE OF BIRTH

18. SEX

19. AGE

20. OCCUPATION

21. CAUSE OF DEATH

22. PLACE OF BIRTH

23. DATE OF BIRTH

24. SEX

25. AGE

26. OCCUPATION

27. CAUSE OF DEATH

28. PLACE OF BIRTH

29. DATE OF BIRTH

30. SEX

31. AGE

32. OCCUPATION

33. CAUSE OF DEATH

34. PLACE OF BIRTH

35. DATE OF BIRTH

36. SEX

37. AGE

38. OCCUPATION

39. CAUSE OF DEATH

40. PLACE OF BIRTH

41. DATE OF BIRTH

42. SEX

43. AGE

44. OCCUPATION

45. CAUSE OF DEATH

46. PLACE OF BIRTH

47. DATE OF BIRTH

48. SEX

49. AGE

50. OCCUPATION

51. CAUSE OF DEATH

52. PLACE OF BIRTH

53. DATE OF BIRTH

54. SEX

55. AGE

56. OCCUPATION

57. CAUSE OF DEATH

58. PLACE OF BIRTH

59. DATE OF BIRTH

60. SEX

61. AGE

62. OCCUPATION

63. CAUSE OF DEATH

64. PLACE OF BIRTH

65. DATE OF BIRTH

66. SEX

67. AGE

68. OCCUPATION

69. CAUSE OF DEATH

70. PLACE OF BIRTH

71. DATE OF BIRTH

72. SEX

73. AGE

74. OCCUPATION

75. CAUSE OF DEATH

76. PLACE OF BIRTH

77. DATE OF BIRTH

78. SEX

79. AGE

80. OCCUPATION

81. CAUSE OF DEATH

82. PLACE OF BIRTH

83. DATE OF BIRTH

84. SEX

85. AGE

86. OCCUPATION

87. CAUSE OF DEATH

88. PLACE OF BIRTH

89. DATE OF BIRTH

90. SEX

91. AGE

92. OCCUPATION

93. CAUSE OF DEATH

94. PLACE OF BIRTH

95. DATE OF BIRTH

96. SEX

97. AGE

98. OCCUPATION

99. CAUSE OF DEATH

100. PLACE OF BIRTH

101. DATE OF BIRTH

102. SEX

103. AGE

104. OCCUPATION

105. CAUSE OF DEATH

106. PLACE OF BIRTH

107. DATE OF BIRTH

108. SEX

109. AGE

110. OCCUPATION

111. CAUSE OF DEATH

112. PLACE OF BIRTH

113. DATE OF BIRTH

114. SEX

115. AGE

116. OCCUPATION

117. CAUSE OF DEATH

118. PLACE OF BIRTH

119. DATE OF BIRTH

120. SEX

121. AGE

122. OCCUPATION

123. CAUSE OF DEATH

124. PLACE OF BIRTH

125. DATE OF BIRTH

126. SEX

127. AGE

128. OCCUPATION

129. CAUSE OF DEATH

130. PLACE OF BIRTH

131. DATE OF BIRTH

132. SEX

133. AGE

134. OCCUPATION

135. CAUSE OF DEATH

136. PLACE OF BIRTH

137. DATE OF BIRTH

138. SEX

139. AGE

140. OCCUPATION

141. CAUSE OF DEATH

142. PLACE OF BIRTH

143. DATE OF BIRTH

144. SEX

145. AGE

146. OCCUPATION

147. CAUSE OF DEATH

148. PLACE OF BIRTH

149. DATE OF BIRTH

150. SEX

151. AGE

152. OCCUPATION

153. CAUSE OF DEATH

154. PLACE OF BIRTH

155. DATE OF BIRTH

156. SEX

157. AGE

158. OCCUPATION

159. CAUSE OF DEATH

160. PLACE OF BIRTH

161. DATE OF BIRTH

162. SEX

163. AGE

164. OCCUPATION

165. CAUSE OF DEATH

166. PLACE OF BIRTH

167. DATE OF BIRTH

168. SEX

169. AGE

170. OCCUPATION

171. CAUSE OF DEATH

172. PLACE OF BIRTH

173. DATE OF BIRTH

174. SEX

175. AGE

176. OCCUPATION

177. CAUSE OF DEATH

178. PLACE OF BIRTH

179. DATE OF BIRTH

180. SEX

181. AGE

182. OCCUPATION

183. CAUSE OF DEATH

184. PLACE OF BIRTH

185. DATE OF BIRTH

186. SEX

187. AGE

188. OCCUPATION

189. CAUSE OF DEATH

190. PLACE OF BIRTH

191. DATE OF BIRTH

192. SEX

193. AGE

194. OCCUPATION

195. CAUSE OF DEATH

196. PLACE OF BIRTH

197. DATE OF BIRTH

198. SEX

199. AGE

200. OCCUPATION

201. CAUSE OF DEATH

202. PLACE OF BIRTH

203. DATE OF BIRTH

204. SEX

205. AGE

206. OCCUPATION

207. CAUSE OF DEATH

208. PLACE OF BIRTH

209. DATE OF BIRTH

210. SEX

211. AGE

212. OCCUPATION

213. CAUSE OF DEATH

214. PLACE OF BIRTH

215. DATE OF BIRTH

216. SEX

217. AGE

218. OCCUPATION

219. CAUSE OF DEATH

220. PLACE OF BIRTH

221. DATE OF BIRTH

222. SEX

223. AGE

224. OCCUPATION

225. CAUSE OF DEATH

226. PLACE OF BIRTH

227. DATE OF BIRTH

228. SEX

229. AGE

230. OCCUPATION

231. CAUSE OF DEATH

232. PLACE OF BIRTH

233. DATE OF BIRTH

234. SEX

235. AGE

236. OCCUPATION

237. CAUSE OF DEATH

238. PLACE OF BIRTH

239. DATE OF BIRTH

240. SEX

241. AGE

242. OCCUPATION

243. CAUSE OF DEATH

244. PLACE OF BIRTH

245. DATE OF BIRTH

246. SEX

247. AGE

248. OCCUPATION

249. CAUSE OF DEATH

250. PLACE OF BIRTH

251. DATE OF BIRTH

252. SEX

253. AGE

254. OCCUPATION

255. CAUSE OF DEATH

256. PLACE OF BIRTH

257. DATE OF BIRTH

258. SEX

259. AGE

260. OCCUPATION

261. CAUSE OF DEATH

262. PLACE OF BIRTH

263. DATE OF BIRTH

264. SEX

265. AGE

266. OCCUPATION

267. CAUSE OF DEATH

268. PLACE OF BIRTH

269. DATE OF BIRTH

270. SEX

271. AGE

272. OCCUPATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12051

CERTIFICATE OF DEATH

12064

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>U.S. Naval Hospital</u>			c. LENGTH OF STAY IN 1b <u>15 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>501 Pine Tree Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>William</u> Last <u>PETTY</u>			4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 August 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Deceased—Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Deceased; Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1919-1946</u>		17. INFORMANT <u>U.S. Naval Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion, Anterior descending</u> DUE TO (c) <u>branch, left # 420.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Half-hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>56</u> to <u>12-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-10-56</u> , 19 <u>56</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12-10-56</u>							
ACTUAL SIGNATURE <u>Vincent P. Butler, Jr.</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Vincent P. Butler Jr Lt. MC USN U.S. Naval Hospital, Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-13-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKINS FUNERAL HOME</u>			ADDRESS <u>ANNAPOLIS, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>12-12-56</u>	24b. REGISTRAR'S SIGNATURE <u>V. French</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

[2]

BUREAU

REC 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12065

12090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3V01-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Queen</u> Last <u>Queen</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. AGE (In years last birthday) <u>51</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Chas. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Joseph Palmer</u>				14. MOTHER'S MAIDEN NAME <u>LUCEY HAWKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>		17. INFORMANT <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left Hemiplegia due to Hypertensive Cardio -</u> DUE TO <u>vascular disease.</u> (c) <u>Pneumonitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 4th</u> , 19 <u>56</u> , to <u>Dec. 24th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/24/56</u> , 19 <u>56</u> , and that death occurred at <u>3:30p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> December 24, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Milton E. Elchman</u>				ADDRESS <u>1129 N. CAROLINE ST.</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. M. Jones</u>			

REC 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12066

Reg. Dist. No.

Item 9 FilmG205 12-27-56 et

1. PLACE OF DEATH a. COUNTY <i>aa</i> 12091		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Best Gate</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Best Gate</i>		d. STREET ADDRESS <i>Lawrence Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Russell William Racey</i>		4. DATE OF DEATH Month Day Year <i>12-9-1956</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-3-1892</i>	
9. AGE (In years last birthday) <i>64</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>West Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles Racey</i>		14. MOTHER'S MAIDEN NAME <i>Leuna Himmel Wright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-12-9639</i>		17. INFORMANT <i>Nellie C. Racey</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>783.1</i> DUE TO <i>Pulmonary Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>12/10/56</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-13-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Nethercrest</i>		22d. LOCATION (City, town, county) (State) <i>Annapolis Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>12/12/56</i>		24b. REGISTRAR'S SIGNATURE <i>V. J. Drunch</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

DEC 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12067

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North Linthicum</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#209 Devon Court</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North Linthicum</u> STREET ADDRESS (If rural give location) <u>#209 Devon Court</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Anne</u> <u>A.</u> <u>Ray</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>21,</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 14, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Ray</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Magruder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr. Thales C. Pumphrey Same As 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>451x Abdominal Aneurism in Decending Aorta</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>sev. yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 20</u> , to <u>Dec. 21, 1956</u> , that I last saw the deceased alive on <u>Dec. 21, 19 56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Jama S. Billingslea</u>		M.D. <u>108 Central Ave. Glen Burnie, Md. 12/28/56</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Brooklyn, RFD, Maryland</u>	
24. REC'D BY REGISTRAR <u>DEC 20 1956</u>		REGISTRAR'S SIGNATURE <u>d. H. Thelach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Lough</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NAME OF DECEASED: **John J. New**
 SEX: **Male**
 AGE: **45**
 DATE OF BIRTH: **Dec. 21, 1905**

PLACE OF BIRTH: **St. Louis, Mo.**

DATE OF DEATH: **Dec. 21, 1950**

CAUSE OF DEATH: **Myocardial infarction**

PLACE OF DEATH: **Home**

SIGNATURE OF PHYSICIAN: **John J. New**

DATE OF SIGNATURE: **Dec. 21, 1950**

PLACE OF SIGNATURE: **Home**

DATE OF DEATH: **Dec. 21, 1950**

PLACE OF DEATH: **Home**

SIGNATURE OF PHYSICIAN: **John J. New**

DATE OF SIGNATURE: **Dec. 21, 1950**

PLACE OF SIGNATURE: **Home**

DATE OF DEATH: **Dec. 21, 1950**

PLACE OF DEATH: **Home**

SIGNATURE OF PHYSICIAN: **John J. New**

BUREAU A. 1

DEC 26 1950

RECEIVED

SMITHSONIAN

WASHINGTON 25, D.C.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12093 **CERTIFICATE OF DEATH**

12068

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>9 hrs 25 min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		30014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>1318 Myrtle Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>ROMONA</u> (First) <u>---</u> (Middle) <u>RYDER</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>December 19</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>December 19, 1956</u>		9. AGE last birthday Yrs. <u>9</u> Min. <u>25</u>	10. IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marvin Ryder</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Margaret Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother, 1318 Myrtle Avenue, Baltimore, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) <u>Immaturity</u>						IMMATUREITY	
ANTECEDENT CAUSE(S) DUE TO						9 hrs 25 min.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>No operation</u>		19b. MAJOR FINDINGS OF OPERATION <u>No operation</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>No injury</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>No injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>18 Dec 56 0810 AM</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Dec 56</u> to <u>19 Dec 56</u> that I last saw the deceased alive on <u>19 Dec 56</u> and that death occurred at <u>0810 AM</u> from the causes and on the date stated above. SIGNATURE <u>RICHARD M. McGUIRE, CAPT, 100D</u> ADDRESS <u>USAH, Ft. Geo. G. Meade Md</u> DATE SIGNED <u>19 Dec 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>24 Dec 56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
24. REC'D BY REGISTRAR <u>DATE 19 Dec 56</u>		REGISTRAR'S SIGNATURE <u>William L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. S. Phillips</u>		ADDRESS <u>1305 N. Baltimore St.</u>	
		WILLIAM L. SAYLOR, 1ST LT, MSC		A. S. PHILLIPS, Baltimore, Md			

2250222XVO

CERTIFICATE OF DEATH

1956

Reg. Dist. No. 32

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, town, or village)

5. Usual residence (Street, city, town, or village)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Disease or injury)

9. Place of death (City, town, or village)

10. Signature of attending physician

11. Signature of registrar

12. Signature of medical examiner

13. Signature of coroner

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of interment

18. Signature of burial

19. Signature of cremation

20. Signature of other

21. Signature of witness

22. Signature of official

23. Signature of clerk

24. Signature of recorder

25. Signature of auditor

26. Signature of treasurer

27. Signature of controller

28. Signature of comptroller

29. Signature of assessor

30. Signature of collector

BUREAU V. S.

DEC 27 1956

RECEIVED

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 13, 14 Film G209 1-14-57 et

12094

CERTIFICATE OF DEATH

12069

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (In this place) <u>43 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> <u>U.S. Army Hosp. Ft. Meade</u>		STREET ADDRESS <u>34 Hunt Club Road</u>		(If rural give location) <u>34 Hunt Club Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>SCHMID</u> (Last) <u>John</u> (Middle)				4. DATE OF DEATH (Month) <u>December</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Wilkes-Barre, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-20-9871</u>		17. INFORMANT & ADDRESS <u>Mrs. Agnes Spahn</u> <u>34 Hunt Club Road, Elkridge, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis and Terminal Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 Nov</u>, 19<u>56</u>, to <u>30 Dec</u>, 19<u>56</u>, that I last saw the deceased alive on <u>30 Dec</u>, 19<u>56</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above.							
SIGNATURE <u>John L. Robertson</u>		JOHN L. ROBERTSON, CAPT, MC, M.D.		ADDRESS (Street, city, town, state) <u>USAH, Fort George G. Meade</u>		DATE SIGNED <u>30 Dec 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/3/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>31 Dec 56</u>		REGISTRAR'S SIGNATURE <u>W.L. SAYLOR, 1ST LT, MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ave, Balto, Md.</u> <u>Elsworth Armacost, 4600 Liberty Heights</u>			

BUREAU V. S.

JAN 8 1957

RECEIVED

12052 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>Rural (Annapolis)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL Hospt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE MABEL SEARS</u>		4. DATE OF DEATH Month Day Year <u>12 3 1956</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>ELHA HILDERBRANT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>BENJAMIN F. SEARS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>55</u> , to <u>3 DEC</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 DEC</u> , 19 <u>56</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>41 Southgate Ave., Annapolis, Md.</u> <u>12/4/56</u> ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>Edward S. Beck M.D.</u> <u>41 Southgate Ave., Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/5/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EDWARDS CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. G. Pa + Sons</u>		24a. REC'D BY REGISTRAR DATE <u>12/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>		25. REGISTRAR'S SIGNATURE <u>J. J. J.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

BUREAU V. S.

DEC 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12095

CERTIFICATE OF DEATH

12071

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Ad</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winchester, Annapolis, Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winchester, Annapolis, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Box 140, R.F.D. 4</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>W.</i> Last <i>Sheppach</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>23</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1873</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>(Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Coal Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Sheppach</i>		14. MOTHER'S MAIDEN NAME <i>Helena Emrich</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. John Fitzpatrick, Winchester, Annapolis, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i> <i>15 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 15, 1956</i> , to <i>Dec 23</i> , 1956, that I last saw the deceased alive on <i>Dec 23</i> , 1956, and that death occurred at <i>6:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>12/23/56</i>			
ACTUAL SIGNATURE <i>J. Borussuck</i> M.D. <i>Amos Garrett Blvd</i>			
PHYSICIAN'S NAME (Type) <i>S. J. Borussuck</i>		<i>Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-26-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR <i>DEC 27 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

RECEIVED

DEC 27 1956

BUREAU V. S.

12096

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harman</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harman</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>GERTRUDE</u> Last <u>SHIPLEY</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> , Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1876</u>		9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME <u>Richard Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Quail</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Glen Burnie, Md</u> <u>Mrs. Catherine S. Walter-Box 6- 107 Crain Hwy SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>15 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>December</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>December 12</u> , 19 <u>56</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>E. Roderick Shipley</u> M.D. <u>721 Medical Arts Bldg</u> PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley M.D.</u> <u>Baltimore 1 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Friendship, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lockner & Sons - Balto 17</u>				ADDRESS <u>Baltimore 17</u>		24b. REC'D BY REGISTRAR DATE <u>17 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara Hachopp</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12073

Reg. Dist. No.

12097

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pratt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>		c. LENGTH OF STAY IN 1b <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pratt</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>338 - Holy Cross Rd.</u>				d. STREET ADDRESS <u>Pratt</u>			
3. NAME OF DECEASED (Type or print) <u>Pamela Sue Skeens</u> First Middle Last				4. DATE OF DEATH <u>12/27/56</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/56</u>		9. AGE (in years last birthday) <u>2</u> yrs. <u>10</u> Months <u>10</u> Days	10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rutgers Hospital, Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Shillie T. Skeens</u>				14. MOTHER'S MAIDEN NAME <u>Lusie Brock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. H.T. Skeens (mother)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>respiratory</u> DUE TO (c) <u>lower</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>9.9. Co.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK INC. 1517 ST PAUL ST</u>				24a. REC'D BY REGISTRAR <u>12-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Edw. H. Johnson</u>	

2046212XV6

E.J.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 MARYLAND AVE.</u>				d. STREET ADDRESS <u>16 MARYLAND AVE.</u>			
3. NAME OF DECEASED (Type or print) <u>CECIL ADA SMITH</u>				4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>C. FRANK SMITH</u>				14. MOTHER'S MAIDEN NAME <u>GRACE TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>J. NORMAN SMITH</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4343</u> DUE TO <u>Indur disease</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> (a), stating the underlying cause lost. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Insider</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & sons</u>				24a. REC'D BY REGISTRAR <u>U. V. V. V.</u> ADDRESS <u>Annapolis, Md.</u>			
				24b. REGISTRAR'S SIGNATURE <u>U. V. V. V.</u> DATE <u>12/12/56</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 13 1944
BUREAU V. S.

1

Item 12 FilmG208 12-21-56 et

12098

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel County</u> MARYLAND ROCK VIEW BEACH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>BALTIMORE</u> b. COUNTY <u>AA.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK VIEW BEACH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE STACHELEK		4. DATE OF DEATH Month Day Year DEC. 13. / 56 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18. 1869 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Konieczny		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Adam Stachelek Son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1956</u> , to <u>12/13, 1956</u> , that I last saw the deceased alive on <u>12/11, 1956</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Rivera Beach, Md.</u> DATE SIGNED <u>12/13/56</u>	
PHYSICIAN'S NAME (Type) <u>J. Brady Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 15/56	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY	22d. LOCATION (City, town, or county) (State) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. OZAZEWSKI		24a. REC'D BY REGISTRAR DATE DEC 17 1956	
ADDRESS 1930 EASTERN AVE.		24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlto</u>	

BUREAU V. 3

1956 17 53

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

12099

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island			
c. LENGTH OF STAY IN 1b 15yrs. 1day				d. STREET ADDRESS None listed			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Blanche		First Blanche		Middle Waters		Last Stanley	
4. DATE OF DEATH		Month 12		Day 10		Year 19 56	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Waters				14. MOTHER'S MAIDEN NAME Bertha Ennels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 134.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Yeast Infection of tonsils DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/3 , 19 56 , to 12/10 , 19 56 , that I last saw the deceased alive on 12/7 , 19 56 , and that death occurred at 5:05 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 12/10/56 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/1956		22c. NAME OF CEMETERY OR CREMATORY Taylor's Island		22d. LOCATION (City, town, or county) (State) Taylor's Island, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Lawrence		ADDRESS Cambridge, Md		24a. REC'D BY REGISTRAR John H. Jones		24b. REGISTRAR'S SIGNATURE John H. Jones	

RECEIVED

BUREAU V. S.

EC 12 1955

12054
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>7 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L.</u> Last <u>STANLEY</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Spotsylvania Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Carnohan</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss June Yvonne Harris</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Circulatory collapse</u> DUE TO (c) <u>Carcinoma Cervix, Stage IV 6-7yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Terminale</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/18, 1956</u> to <u>12/18, 1956</u> , that I last saw the deceased alive on <u>12/18, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Churchill J. Franklin</u>				DATE SIGNED <u>12/19/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Churchill J. Franklin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Light</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>525155</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mays</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mays</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>AGNES</i> Middle <i>MARY</i> Last <i>Stromberg</i>		4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/4/97</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months <i>12</i> Days <i>28</i> Hours <i>56</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor - Peoples Life Ins. Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington DC.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas A. Keleher</i>		14. MOTHER'S MAIDEN NAME <i>Frances J. Mottley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-24-5586</i>	
17. INFORMANT <i>Clifton Q. Stromberg</i> Address <i>husband</i>		18. CAUSE OF DEATH [Enter only one cause per life for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Bacterial meningitis</i> DUE TO (b) <i>170X</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Due to</i> DUE TO (c) <i>8 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/31/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Smithland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Galley's Funeral Home, Inc.</i>		ADDRESS <i>Mt. Rainier</i>	
24. REC'D BY REGISTRAR <i>JAN 2 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie Smith</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE		HOURS	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		SIGNS		TESTS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		X-RAY EXAMINATION		PATHOLOGICAL EXAMINATION		TOXICOLOGICAL EXAMINATION	
FINDINGS		DISCUSSION		CONCLUSIONS		REMARKS		SIGNATURE		TITLE	

RECEIVED
JAN 2 1957
BUREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12079

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH COUNTY <u>ANNIE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>GLENBURNIE</u> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> TOWN <u>3101.4</u> STREET ADDRESS (If rural, give location) <u>714 Dolphin St.</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLIE</u> (First) <u>SUGARS</u> (Last)				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>18</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S.</u>	8. DATE OF BIRTH <u>JAN, 18, 1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lapman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sugars</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or none.) <u>Yes WWI</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Adeline Neal 714 Dolphin St.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROSIS</u>							
ANTECEDENT CAUSE(S) DUE TO <u>GENERAL</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Dec 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>6</u> M., from the causes and on the date stated above.							
SIGNATURE <u>WCM Taler</u>		ADDRESS (Street, city, town, state) <u>102 Balto. Annap. Blvd. Md.</u>		DATE SIGNED <u>Dec. 18, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/21/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		LOCATION (City, town, of county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edith Deady</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate R. Williams</u>		ADDRESS <u>322 N. Schroeder St.</u>	
DATE <u>12/20/56</u>							

CERTIFICATE OF DEATH

Form 10-1-55

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH OFFICIAL

16. SIGNATURE OF CEMETERY OFFICIAL

17. SIGNATURE OF OTHER OFFICIAL

18. SIGNATURE OF OTHER OFFICIAL

19. SIGNATURE OF OTHER OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

23. SIGNATURE OF OTHER OFFICIAL

24. SIGNATURE OF OTHER OFFICIAL

25. SIGNATURE OF OTHER OFFICIAL

26. SIGNATURE OF OTHER OFFICIAL

27. SIGNATURE OF OTHER OFFICIAL

28. SIGNATURE OF OTHER OFFICIAL

29. SIGNATURE OF OTHER OFFICIAL

30. SIGNATURE OF OTHER OFFICIAL

31. SIGNATURE OF OTHER OFFICIAL

32. SIGNATURE OF OTHER OFFICIAL

33. SIGNATURE OF OTHER OFFICIAL

34. SIGNATURE OF OTHER OFFICIAL

35. SIGNATURE OF OTHER OFFICIAL

36. SIGNATURE OF OTHER OFFICIAL

37. SIGNATURE OF OTHER OFFICIAL

38. SIGNATURE OF OTHER OFFICIAL

39. SIGNATURE OF OTHER OFFICIAL

40. SIGNATURE OF OTHER OFFICIAL

41. SIGNATURE OF OTHER OFFICIAL

42. SIGNATURE OF OTHER OFFICIAL

43. SIGNATURE OF OTHER OFFICIAL

44. SIGNATURE OF OTHER OFFICIAL

45. SIGNATURE OF OTHER OFFICIAL

46. SIGNATURE OF OTHER OFFICIAL

47. SIGNATURE OF OTHER OFFICIAL

48. SIGNATURE OF OTHER OFFICIAL

49. SIGNATURE OF OTHER OFFICIAL

50. SIGNATURE OF OTHER OFFICIAL

51. SIGNATURE OF OTHER OFFICIAL

52. SIGNATURE OF OTHER OFFICIAL

53. SIGNATURE OF OTHER OFFICIAL

54. SIGNATURE OF OTHER OFFICIAL

55. SIGNATURE OF OTHER OFFICIAL

56. SIGNATURE OF OTHER OFFICIAL

57. SIGNATURE OF OTHER OFFICIAL

58. SIGNATURE OF OTHER OFFICIAL

59. SIGNATURE OF OTHER OFFICIAL

60. SIGNATURE OF OTHER OFFICIAL

61. SIGNATURE OF OTHER OFFICIAL

62. SIGNATURE OF OTHER OFFICIAL

63. SIGNATURE OF OTHER OFFICIAL

64. SIGNATURE OF OTHER OFFICIAL

65. SIGNATURE OF OTHER OFFICIAL

66. SIGNATURE OF OTHER OFFICIAL

67. SIGNATURE OF OTHER OFFICIAL

68. SIGNATURE OF OTHER OFFICIAL

69. SIGNATURE OF OTHER OFFICIAL

70. SIGNATURE OF OTHER OFFICIAL

71. SIGNATURE OF OTHER OFFICIAL

72. SIGNATURE OF OTHER OFFICIAL

73. SIGNATURE OF OTHER OFFICIAL

74. SIGNATURE OF OTHER OFFICIAL

75. SIGNATURE OF OTHER OFFICIAL

76. SIGNATURE OF OTHER OFFICIAL

77. SIGNATURE OF OTHER OFFICIAL

78. SIGNATURE OF OTHER OFFICIAL

79. SIGNATURE OF OTHER OFFICIAL

80. SIGNATURE OF OTHER OFFICIAL

81. SIGNATURE OF OTHER OFFICIAL

82. SIGNATURE OF OTHER OFFICIAL

83. SIGNATURE OF OTHER OFFICIAL

84. SIGNATURE OF OTHER OFFICIAL

85. SIGNATURE OF OTHER OFFICIAL

86. SIGNATURE OF OTHER OFFICIAL

87. SIGNATURE OF OTHER OFFICIAL

88. SIGNATURE OF OTHER OFFICIAL

89. SIGNATURE OF OTHER OFFICIAL

90. SIGNATURE OF OTHER OFFICIAL

91. SIGNATURE OF OTHER OFFICIAL

92. SIGNATURE OF OTHER OFFICIAL

93. SIGNATURE OF OTHER OFFICIAL

94. SIGNATURE OF OTHER OFFICIAL

95. SIGNATURE OF OTHER OFFICIAL

96. SIGNATURE OF OTHER OFFICIAL

97. SIGNATURE OF OTHER OFFICIAL

98. SIGNATURE OF OTHER OFFICIAL

99. SIGNATURE OF OTHER OFFICIAL

100. SIGNATURE OF OTHER OFFICIAL

101. SIGNATURE OF OTHER OFFICIAL

102. SIGNATURE OF OTHER OFFICIAL

103. SIGNATURE OF OTHER OFFICIAL

104. SIGNATURE OF OTHER OFFICIAL

105. SIGNATURE OF OTHER OFFICIAL

106. SIGNATURE OF OTHER OFFICIAL

107. SIGNATURE OF OTHER OFFICIAL

108. SIGNATURE OF OTHER OFFICIAL

109. SIGNATURE OF OTHER OFFICIAL

110. SIGNATURE OF OTHER OFFICIAL

111. SIGNATURE OF OTHER OFFICIAL

112. SIGNATURE OF OTHER OFFICIAL

113. SIGNATURE OF OTHER OFFICIAL

114. SIGNATURE OF OTHER OFFICIAL

115. SIGNATURE OF OTHER OFFICIAL

116. SIGNATURE OF OTHER OFFICIAL

117. SIGNATURE OF OTHER OFFICIAL

118. SIGNATURE OF OTHER OFFICIAL

119. SIGNATURE OF OTHER OFFICIAL

120. SIGNATURE OF OTHER OFFICIAL

121. SIGNATURE OF OTHER OFFICIAL

122. SIGNATURE OF OTHER OFFICIAL

123. SIGNATURE OF OTHER OFFICIAL

124. SIGNATURE OF OTHER OFFICIAL

125. SIGNATURE OF OTHER OFFICIAL

126. SIGNATURE OF OTHER OFFICIAL

127. SIGNATURE OF OTHER OFFICIAL

128. SIGNATURE OF OTHER OFFICIAL

129. SIGNATURE OF OTHER OFFICIAL

130. SIGNATURE OF OTHER OFFICIAL

131. SIGNATURE OF OTHER OFFICIAL

132. SIGNATURE OF OTHER OFFICIAL

133. SIGNATURE OF OTHER OFFICIAL

134. SIGNATURE OF OTHER OFFICIAL

135. SIGNATURE OF OTHER OFFICIAL

136. SIGNATURE OF OTHER OFFICIAL

137. SIGNATURE OF OTHER OFFICIAL

138. SIGNATURE OF OTHER OFFICIAL

139. SIGNATURE OF OTHER OFFICIAL

140. SIGNATURE OF OTHER OFFICIAL

141. SIGNATURE OF OTHER OFFICIAL

142. SIGNATURE OF OTHER OFFICIAL

143. SIGNATURE OF OTHER OFFICIAL

144. SIGNATURE OF OTHER OFFICIAL

145. SIGNATURE OF OTHER OFFICIAL

146. SIGNATURE OF OTHER OFFICIAL

147. SIGNATURE OF OTHER OFFICIAL

148. SIGNATURE OF OTHER OFFICIAL

149. SIGNATURE OF OTHER OFFICIAL

150. SIGNATURE OF OTHER OFFICIAL

151. SIGNATURE OF OTHER OFFICIAL

152. SIGNATURE OF OTHER OFFICIAL

153. SIGNATURE OF OTHER OFFICIAL

154. SIGNATURE OF OTHER OFFICIAL

155. SIGNATURE OF OTHER OFFICIAL

156. SIGNATURE OF OTHER OFFICIAL

157. SIGNATURE OF OTHER OFFICIAL

158. SIGNATURE OF OTHER OFFICIAL

159. SIGNATURE OF OTHER OFFICIAL

160. SIGNATURE OF OTHER OFFICIAL

161. SIGNATURE OF OTHER OFFICIAL

162. SIGNATURE OF OTHER OFFICIAL

163. SIGNATURE OF OTHER OFFICIAL

164. SIGNATURE OF OTHER OFFICIAL

165. SIGNATURE OF OTHER OFFICIAL

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT, AND IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS.

BUREAU V. B.

DEC 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13104

12102

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 25yrs.2mos.28days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Stump Alley			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Tasker Last Tasker				4. DATE OF DEATH Month 12 Day 29 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not listed	
9. AGE (In years last birthday) yrs. 75?		IF UNDER 1 YEAR Months 75? Days 75? Hours 75? Min. 75?		IF UNDER 24 HRS. Months 75? Days 75? Hours 75? Min. 75?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Nathaniel Tasker				14. MOTHER'S MAIDEN NAME Esther Ann Goldberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Arteriosclerosis with Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia with Pyelonephritis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/22/1956 , to 12/29/1956 , that I last saw the deceased alive on 12/28/1956 , and that death occurred at 11:00p AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 12/29/56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-4-57		22c. NAME OF CEMETERY OR CREMATOR University of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.				24a. REC'D BY REGISTRAR 10 1957		24b. REGISTRAR'S SIGNATURE H. M. Jones	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE DAY

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		M		35		1922		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
JONES & CO.		HIGH SCHOOL		MARRIED		1945		BALTIMORE		MD		USA			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CITY		STATE		COUNTRY	
JAN 10 1957		BALTIMORE		HEART DISEASE		NATURAL		JONES		MD		USA			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		CITY		STATE		COUNTRY	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		BALTIMORE		MD		USA	

BUREAU V. S.

JAN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12103

CERTIFICATE OF DEATH

12080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Garrett Road</u>				d. STREET ADDRESS <u>101 Garrett Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adam Miller Taylor</u>				4. DATE OF DEATH Month Day Year <u>December 7, 1956</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Taylor</u> XXXXXXXXXXXX				14. MOTHER'S MAIDEN NAME <u>Deans Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-0309</u>		17. INFORMANT <u>Robert E. Taylor</u> Address <u>101 Garrett Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cholera in Relapsing</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic Hemiplegia</u> (c) <u>Generalized arteriosclerosis</u> DUE TO <u>Chronic Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>At Hemiplegia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Nov 18/56</u> <u>4-4-56</u> <u>2-7-56</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 16, 1956</u> , to <u>Dec 7, 1956</u> , that I last saw the deceased alive on <u>Dec 5, 1956</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>4619 Manin St Ellicott City Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>12/8/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
				DATE <u>DEC 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort G. G. Meade		c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Army Hospital				d. STREET ADDRESS 304 Washington Avenue			
3. NAME OF DECEASED (Type or print) First BLANCHE Middle — Last THOMPSON				4. DATE OF DEATH Month December Day 31 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1920	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Serv.		11. BIRTHPLACE (State or foreign country) Gleyida, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C. W. Dinsmore				14. MOTHER'S MAIDEN NAME Mary Redwine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-01-1477		17. INFORMANT Address Omer R. Dinsmore, Brother, Box 176, Route 17, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Sudden DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm, Sudden DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3 Hours 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour — a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7/57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton				24a. REC'D BY REGISTRAR DEC 31, 56		24b. REGISTRAR'S SIGNATURE W. W. Saylor, 1st Lt, MSC	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Death: [illegible]
5. Place of Death: [illegible]
6. Cause of Death: [illegible]
7. Manner of Death: [illegible]
8. Signature of Examiner: [illegible]
9. Date of Examination: [illegible]

BUREAU V. 8

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12082

12105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Pt. Pleasant</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>B Pt. Pleasant</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 238 - Turnage Ave</u>				d. STREET ADDRESS <u>TURNAGE AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WM</u>		First <u>Harry</u> Middle <u>Thompson</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/70</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crabber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sold Vegetables Baltimore Md</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM H. Thompson Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Woods</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Kathleen Finan - (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus Infection (Cold -)</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/18/56</u> , 19 <u>56</u> , to <u>12/18</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12/18/56</u> , 19 <u>56</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas - L - Bell</u>				DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>12-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Coney</u>				ADDRESS <u>Shaw House</u>			
24a. REC'D BY REGISTRAR <u>DEC 19 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Deady</u>					

100

BUREAU

DEC 20 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

12106
CERTIFICATE OF DEATH
12083
Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#8 Wilson Blvd., S.W.</u>				STREET ADDRESS (If rural give location) <u>#8 Wilson Blvd., S.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>Wilbert T. Travers, Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 8, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 11, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.&O.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert A. Travers</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Marguerite M. Travers. #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>163x Carcinoma of the lung, right with</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/13/ 19 55</u> to <u>12/8/ 19 56</u> , that I last saw the deceased alive on <u>12/8/ 19 56</u> , and that death occurred at <u>3: P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Glen Burnie, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	
DATE <u>DEC 11 1956</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1908

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX AND AGE

3. OCCUPATION

4. PLACE OF BIRTH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF COURT

16. SIGNATURE OF STATE

17. SIGNATURE OF COUNTY

18. SIGNATURE OF CITY

19. SIGNATURE OF TOWNSHIP

20. SIGNATURE OF PARISH

21. SIGNATURE OF VILLAGE

22. SIGNATURE OF HAMLET

23. SIGNATURE OF CENSUS TRACT

24. SIGNATURE OF BLOCK

25. SIGNATURE OF HOUSE

26. SIGNATURE OF ROOM

27. SIGNATURE OF BED

28. SIGNATURE OF CHAIR

29. SIGNATURE OF TABLE

30. SIGNATURE OF CUPBOARD

31. SIGNATURE OF SHED

32. SIGNATURE OF GARAGE

33. SIGNATURE OF PORCH

34. SIGNATURE OF PATIO

35. SIGNATURE OF DRIVE

36. SIGNATURE OF WALK

37. SIGNATURE OF FENCE

38. SIGNATURE OF GATE

39. SIGNATURE OF POST

40. SIGNATURE OF RAIL

41. SIGNATURE OF ROAD

42. SIGNATURE OF BRIDGE

43. SIGNATURE OF TUNNEL

44. SIGNATURE OF CANYON

45. SIGNATURE OF MOUNTAIN

BUREAU V. 3.

DEC 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12084

12107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 19 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #110 Second Ave., S.W.				d. STREET ADDRESS #110 Second Ave., S.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Martha Middle M. Last Upton				4. DATE OF DEATH Month December Day 13 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Herman Duberke				14. MOTHER'S MAIDEN NAME Agusta Lux			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Reuben W. Upton		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Ventr Infarction DUE TO (c) 10 days							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1955, to Dec 13 , 1956, that I last saw the deceased alive on Dec 13 , 1956, and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE James S. Billingsley M.D. 105 Central Ave. Glen Burnie. Dec 14, 1956							
PHYSICIAN'S NAME (Type) James S. Billingsley M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. H. H.				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DEC 18 1956	
				24b. REGISTRAR'S SIGNATURE L. J. Sealbay			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12107

Name of Deceased John Smith		Sex Male		Age 45 years	
Date of Birth Jan 15, 1880		Place of Birth Maryland		Usual Residence 110 Second Ave., S.E., Wash. D.C.	
Date of Death Dec 15, 1956		Place of Death Home		Cause of Death Heart Disease	
Time of Death 10:30 A.M.		Physician's Name Dr. J. H. Jones		Hospital or Place of Care None	
Signature of Physician J. H. Jones		Signature of Registrar J. H. Jones		Signature of Informant J. H. Jones	

BUREAU V. S.

DEC 17 1956

RECEIVED

12108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magothy Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>—</u> Last <u>Van Iderstine</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Van Iderstine</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Skinner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>yes</u> <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>wife - Louise Gibson Island</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 3</u> , 1956, to <u>Dec. 30</u> , 1956, that I last saw the deceased alive on <u>Dec. 30</u> , 1956, and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kathleen H. Lyons</u> M.D.				ADDRESS (Street, city or town, state) <u>Paisley Rd, Gibson Island, Md.</u>			
DATE SIGNED <u>12/30/56</u>				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>Jan. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>N. J. & N. Y. Cremation Co</u>		22d. LOCATION (City, town, or county) (State) <u>North Bergen N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>JAN 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Robert Van Iderstine	
Sex		Male	
Race		White	
Date of Birth		July 2, 1875	
Place of Birth		New York	
Usual Residence		New York	
Cause of Death		Anteriorly located heart disease	
Duration of Illness		Intermittent	
Place of Death		New York	
Date of Death		July 2, 1957	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. 1

JUL 9 1957

RECEIVED

Name of Registrar		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		July 9, 1957	

12055

CERTIFICATE OF DEATH

12087

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNH				c. LENGTH OF STAY IN 1b 30 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 1305 Stevens Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin First Bruce Middle WATTS Last				4. DATE OF DEATH Month December Day 3 Year 19 56			
5. SEX Male	6. COLOR OR RACE Ca.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-96		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.N. Retired		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nathan Peter WATTS				14. MOTHER'S MAIDEN NAME Ella Virginia KAEISER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI-- WW2		16. SOCIAL SECURITY NO. 218262876		17. INFORMANT USNH Records		Address Annapolis, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, Cause unknown 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 Hr 1/2	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3-56 , 19 56 , to 12-3- , 19 56 , that I last saw the deceased alive on 12-3- , 19 56 , and that death occurred at 12:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE P.O. Leib M.D.				PHYSICIAN'S NAME (Type) P.O. GEIB CDR MC USN U.S.N.H. Annapolis, Md. 12-3-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR DEC 5 1956 24b. REGISTRAR'S SIGNATURE Dr. M. J. Lench	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED
DEC 5 1956
BUREAU V. J.

DEC 5 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **12088**
12109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy Beach</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Cynthia Marie Willard</u>				4. DATE OF DEATH <u>December 13th</u> 19 <u>56</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11/23/56</u>		9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months <u>20</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond William Willard</u>				14. MOTHER'S MAIDEN NAME <u>Claire Marie Hammel</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. R.W. Willard (mother)</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of pulmonary tract</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Few Hours.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				DATE SIGNED <u>12/13/56</u>				
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS				24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
<u>Glen Burnie, Md.</u>				DATE <u>DEC 14 1956</u>				

2040294XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. B.

DEC 14 1956

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. RACE: [illegible]
5. DATE OF BIRTH: [illegible]
6. PLACE OF BIRTH: [illegible]
7. OCCUPATION: [illegible]
8. CAUSE OF DEATH: [illegible]
9. MANNER OF DEATH: [illegible]
10. SIGNATURE OF EXAMINER: [illegible]
11. DATE OF EXAMINATION: [illegible]